

12859

CERTIFICATE OF DEATH

12794

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHILLUM</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1408 LEGATION ROAD</b>				d. STREET ADDRESS <b>1408 LEGATION ROAD</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>THEODORE WILLIAM ALEXANDER</b>				4. DATE OF DEATH Month Day Year <b>NOV. 25 19 58</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/19/86</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill man (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Milling &amp; Lumber Co.</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN S. ALEXANDER</b>				14. MOTHER'S MAIDEN NAME <b>MATILDA HILLARY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO. <b>578-03-6234</b>		17. INFORMANT Address <b>Mrs Leo P. Darr, 1408 Legation Rd., Chillum, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Thrombotic Embolism of Heart</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio-sclerotic Heart disease</b> DUE TO <b>Arterio-sclerotic Heart disease</b> (c) <b>Arterio-sclerotic Heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/19</b> , 19 <b>53</b> , to <b>11/25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/25</b> , 19 <b>58</b> , and that death occurred at <b>6:05 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Francis X. Richardson</b> M.D.				ADDRESS (Street, city or town, state) <b>7717 - Alosha Ave NW. WASH. D.C.</b> DATE SIGNED <b>11/25/58</b>			
PHYSICIAN'S NAME (Type) <b>FRANCIS X. RICHARDSON</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/29/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> ADDRESS <b>SILVER SPRING, MD.</b>				24a. REC'D BY REGISTRAR <b>NOV 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hous</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1923

10701

<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Signature of informant</p>		<p>12. Date of registration</p>	
<p>13. Signature of registrar</p>		<p>14. Date of registration</p>	
<p>15. Signature of registrar</p>		<p>16. Date of registration</p>	
<p>17. Signature of registrar</p>		<p>18. Date of registration</p>	
<p>19. Signature of registrar</p>		<p>20. Date of registration</p>	
<p>21. Signature of registrar</p>		<p>22. Date of registration</p>	
<p>23. Signature of registrar</p>		<p>24. Date of registration</p>	
<p>25. Signature of registrar</p>		<p>26. Date of registration</p>	
<p>27. Signature of registrar</p>		<p>28. Date of registration</p>	
<p>29. Signature of registrar</p>		<p>30. Date of registration</p>	
<p>31. Signature of registrar</p>		<p>32. Date of registration</p>	
<p>33. Signature of registrar</p>		<p>34. Date of registration</p>	
<p>35. Signature of registrar</p>		<p>36. Date of registration</p>	
<p>37. Signature of registrar</p>		<p>38. Date of registration</p>	
<p>39. Signature of registrar</p>		<p>40. Date of registration</p>	
<p>41. Signature of registrar</p>		<p>42. Date of registration</p>	
<p>43. Signature of registrar</p>		<p>44. Date of registration</p>	
<p>45. Signature of registrar</p>		<p>46. Date of registration</p>	
<p>47. Signature of registrar</p>		<p>48. Date of registration</p>	
<p>49. Signature of registrar</p>		<p>50. Date of registration</p>	
<p>51. Signature of registrar</p>		<p>52. Date of registration</p>	
<p>53. Signature of registrar</p>		<p>54. Date of registration</p>	
<p>55. Signature of registrar</p>		<p>56. Date of registration</p>	
<p>57. Signature of registrar</p>		<p>58. Date of registration</p>	
<p>59. Signature of registrar</p>		<p>60. Date of registration</p>	
<p>61. Signature of registrar</p>		<p>62. Date of registration</p>	
<p>63. Signature of registrar</p>		<p>64. Date of registration</p>	
<p>65. Signature of registrar</p>		<p>66. Date of registration</p>	
<p>67. Signature of registrar</p>		<p>68. Date of registration</p>	
<p>69. Signature of registrar</p>		<p>70. Date of registration</p>	
<p>71. Signature of registrar</p>		<p>72. Date of registration</p>	
<p>73. Signature of registrar</p>		<p>74. Date of registration</p>	
<p>75. Signature of registrar</p>		<p>76. Date of registration</p>	
<p>77. Signature of registrar</p>		<p>78. Date of registration</p>	
<p>79. Signature of registrar</p>		<p>80. Date of registration</p>	
<p>81. Signature of registrar</p>		<p>82. Date of registration</p>	
<p>83. Signature of registrar</p>		<p>84. Date of registration</p>	
<p>85. Signature of registrar</p>		<p>86. Date of registration</p>	
<p>87. Signature of registrar</p>		<p>88. Date of registration</p>	
<p>89. Signature of registrar</p>		<p>90. Date of registration</p>	
<p>91. Signature of registrar</p>		<p>92. Date of registration</p>	
<p>93. Signature of registrar</p>		<p>94. Date of registration</p>	
<p>95. Signature of registrar</p>		<p>96. Date of registration</p>	
<p>97. Signature of registrar</p>		<p>98. Date of registration</p>	
<p>99. Signature of registrar</p>		<p>100. Date of registration</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12808

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15 Hyattsville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>				d. STREET ADDRESS <u>7510 Hawthorne St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Franklin</u> Last <u>Alvey</u>				4. DATE OF DEATH Month <u>11</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30-1912</u>		9. AGE (In years last birthday) <u>46</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>6</u>	IF UNDER 24 HRS. Hours <u>4</u> Min. <u>6</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Edward T. Alvey</u>				14. MOTHER'S MAIDEN NAME <u>Rose C. Hancock</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.2</u>		16. SOCIAL SECURITY NO. <u>217-07-8906</u>		17. INFORMANT <u>Myrtle Alvey - Same address as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Compression &amp; necrosis.</u>							
900.6 DUE TO (b) <u>Subdural and epidural hemorrhage</u>							
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>Fracture of skull</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Blow on head caused by fall down stairs.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>6:50</u> a.m. <u>11-7-1958</u>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>School</u>		20f. City or town <u>Bradbury Hts Pr. Geo Md</u>	
20g. County <u>Pr. Geo</u>		20h. State <u>Md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John J. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>11-10-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12809

CERTIFICATE OF DEATH

Reg. Dist. No.

12796

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Hgts.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 56 Capitol Heights,	
d. NAME OF HOSPITAL (If not in hospital, give street address) 5801 F St.		d. STREET ADDRESS 5801 F St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Frank Antonio		4. DATE OF DEATH Month Day Year Nov. 24 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Aug. 1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) had hat concession at		10b. KIND OF BUSINESS OR INDUSTRY Statler Hotel in D.C.	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 212-24-2547	
17. INFORMANT Mary Antonio		Address 5801 F St. Cap. Hgts. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Pneumonia Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/9, 1958, to 11/24, 1958, that I last saw the deceased alive on Nov 19, 1958, and that death occurred at 9:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry M. Carlton		ADDRESS (Street, city or town, state) 1816 R. St. N.W. Wash. DC.	
DATE SIGNED 11/24/58			
PHYSICIAN'S NAME (Type) HARRY M. CARLTON		1816 R. St. N.W. Wash. DC.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 26 Nov. '58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		22d. LOCATION (City, town, or county) (State) Wash., D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funera 1		ADDRESS Home 4 & Mass av. N. E.	
24a. REC'D BY REGISTRAR NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	



12-20 STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 9 FilmG237 1-7-59 et

12799

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale, Md	c. LENGTH OF STAY IN 1b transient	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 25 Riverdale Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore & Ohio R.R. Tracks		d. STREET ADDRESS 4804 Tuckerman St	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELIZABETH ROSE BALINOVIC		4. DATE OF DEATH Month Day Year November 21, 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 7, 1907
9. AGE (In years and birthday) 32 1/2 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY U S A		13. FATHER'S NAME Andrew Burless	
14. MOTHER'S MAIDEN NAME Pet Mary Budner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 578/83199		17. INFORMANT Peter Balinovic Address Riverdale, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and shock 802X DUE TO Conditions, if any, which gave rise to immediate cause (b) Trauma, multiple and severe (c), stating the underlying cause lost DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Struck by passenger train	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 8.19 a. m. 11/21/58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R.R. Tracks		20f. (City or town) (County) (State) Riverdale Pr. Gee. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John T. Maloney		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. John T. Maloney		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED November 22, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-58	
22c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colman Manor Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Smith			

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
CERTIFICATE OF DEATH

Decedent's Name

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Place of Birth

Date of Birth

Place of Death

Signature of Registrar



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12860

## CERTIFICATE OF DEATH

12800

Reg. Dist. No.

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>PR. GEO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>PR. GEO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>MARLBORO</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MARLBORO</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SERVICE LANE</u>				STREET ADDRESS (If rural give location) <u>SERVICE LANE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>MARY ELIZABETH BARNETT</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11 1 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>2-20-1939</u>	9. AGE last birthday <u>19</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WASHINGTON, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ALEXANDER BARNETT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SPRIGGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
201X IMMEDIATE CAUSE (A) <u>Hodgkin's Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Conjunctive Heart Failure</u>				<u>Two days</u>			
19a. DATE OF OPERATION <u>no</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 1</u> , 19 <u>58</u> , to <u>Nov 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>58</u> , and that death occurred at <u>11 A</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>James B. Bascor</u> M.D.				ADDRESS (Street, city, town, state) <u>Upper Marlboro Md 20784</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/5/58</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Upper Marlboro, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>NOV 5 '58</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Evans</u> ADDRESS <u>30 H. Ave.</u>			

# CERTIFICATE OF DEATH

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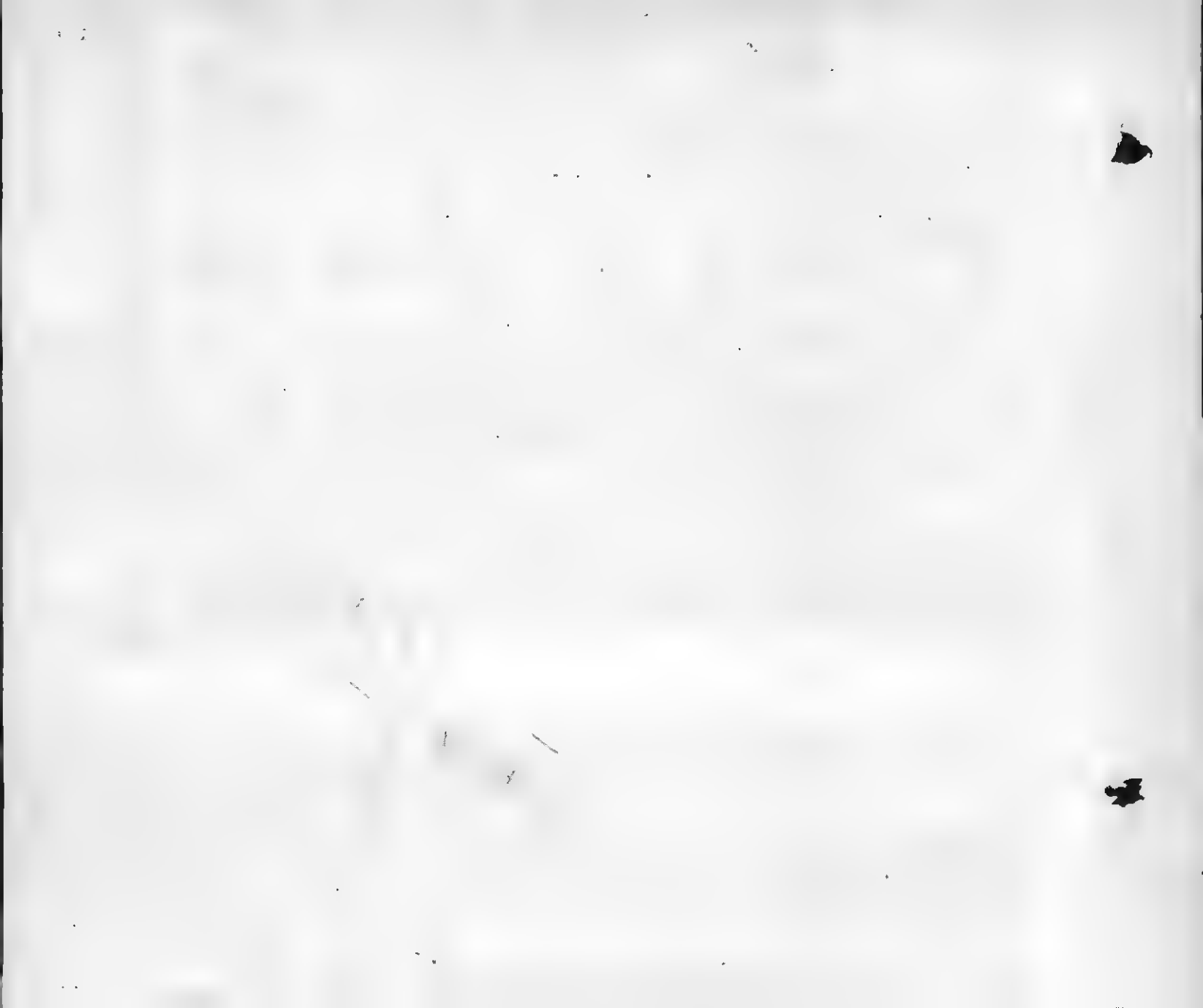
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## MEDICAL CERTIFICATION

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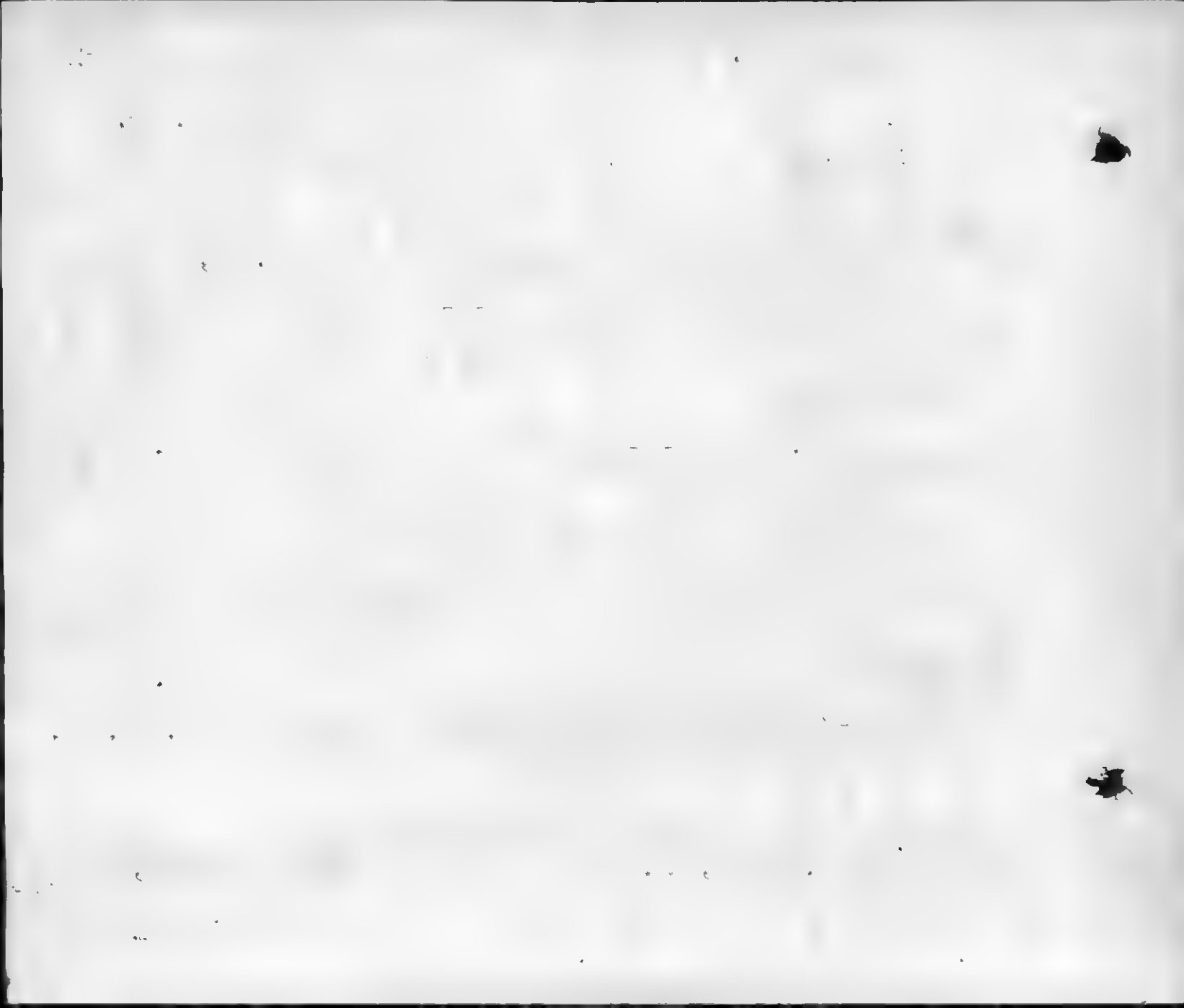
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
c. LENGTH OF STAY IN 1b <b>8 years</b>		d. STREET ADDRESS <b>5011 38th Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5011 38th Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George Thomas Bielonis</b>		4. DATE OF DEATH <b>Nov. 21, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OF RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-19-09</b>
9. AGE (In years last birthday) <b>48 yrs</b>		10. IF UNDER 1 YEAR: Months <b>48</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Bielonis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Gwasditis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>188-09-1381</b>	
17. INFORMANT <b>Mary Bielonis; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>891.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carbon monoxide poisoning</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Asphyxia due to inhalation of fumes from automobile.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>11-21-58</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home (garage)</b>		20f. (City or town) <b>Hyattsville</b> (County) <b>Pr. Geo.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>November 22, 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 25, 1958</b>	
22c. NAME OF CEMETERY OR INTERMENT ADDRESS <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>Arlington Va.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 26 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12812

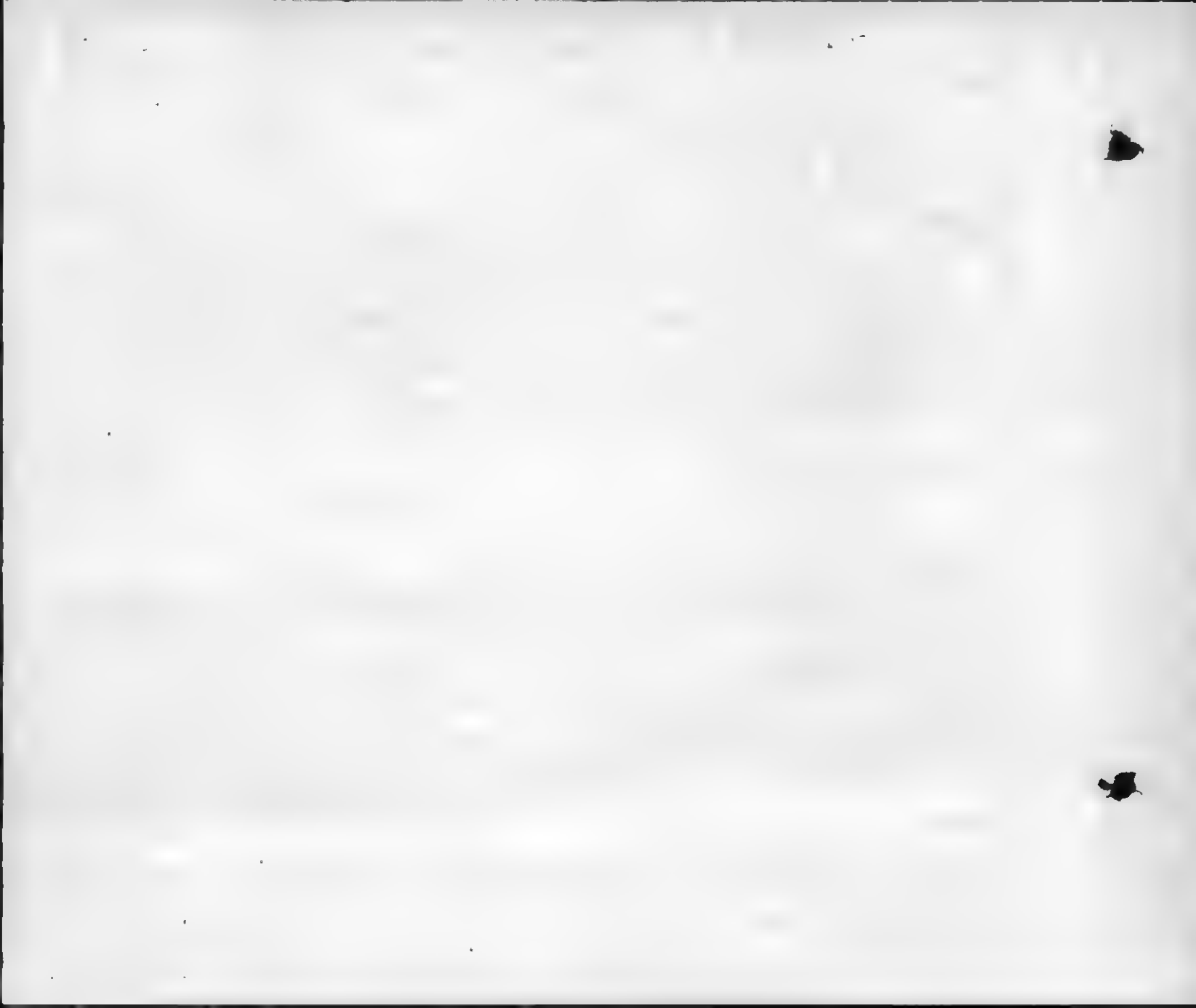
## CERTIFICATE OF DEATH

Reg. Dist. No.

12803

1. PLACE OF DEATH a COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a STATE Maryland b COUNTY Prince George's	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital		e STREET ADDRESS 6911 Carleton Terrace	
3. NAME OF DECEASED (Type or print) First MIDDLE Last GLADYS GARCIA BOLLINGER		4. DATE OF DEATH Month Day Year Nov 15, 1958	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 18, 1897
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY Public school	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Frank King		14. MOTHER'S MAIDEN NAME Savilla ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Philip H Bollinger		Address College Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral haemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 13, 1958</u> to <u>Nov 15, 1958</u> that I last saw the deceased alive on <u>Nov 14, 1958</u> and that death occurred at <u>64</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Hyattsville, Md.</u> <u>11-15-58</u> ACTUAL SIGNATURE <u>Leonard Hays</u> M.D. <u>Hyattsville, Md.</u> PHYSICIAN'S NAME (Type) <u>Leonard Hays</u> <u>Hyattsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 17, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F Gasch sons		24a. REC'D BY REGISTRAR DATE NOV 18 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12804

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pt Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. LENGTH OF STAY IN 1b <u>DDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenarden</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>				e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u>		First Middle Last <u>Brooks</u>		4. DATE OF DEATH <u>11-8-1958</u>		Month Day Year	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-1-18</u>	
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Otha Paul Wheeler</u>				14. MOTHER'S MAIDEN NAME <u>Mary Washington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mary Wheeler; Glenarden, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: (a) <u>16X Hemorrhage &amp; shock</u> DUE TO (b) <u>severance of thoracic aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Occupant of a parked auto - struck by another Automobile</u>			
20c. TIME OF INJURY Month, Day, Year <u>4-04-11-8-1958</u>				20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Highway</u>	
20f. City or town <u>Sanctum - Pt Geo - Md</u>				20g. (County) <u>Pt Geo</u>		20h. (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John T. Maloney</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John T. Maloney M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-12-58</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Family</u>	
22d. LOCATION (City, town, or county) <u>Woodmore Md</u>				22e. (State) <u>Md</u>		22f. REC'D BY REGISTRAR	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Schuchman</u>				23a. ADDRESS <u>467 N 1st St</u>		23b. REGISTRAR'S SIGNATURE <u>L. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item, 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12796

## CERTIFICATE OF DEATH

Reg. Dist. No. 12805

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 5323 Greenway Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Beatrice Bruno		4. DATE OF DEATH Month Day Year November 13, 19 58-	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 31, 1884
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME John Bevalaque		14. MOTHER'S MAIDEN NAME Anna ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rose Bruno		Address Hyattsville Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1958 to 11-13-58, and that I last saw the deceased alive on 11-12-58, and that death occurred at 4 A. M. from the causes and on the date stated above ADDRESS (Street, City or town, state) DATE SIGNED F. Gasch's Sons Hyattsville, Md. Hyattsville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 15, 1958	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		24a. REC'D BY REGISTRAR DATE NOV 17 '58	
ADDRESS Hyattsville, Maryland.		24b. REGISTRAR'S SIGNATURE William A. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12814

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>36 Capital Hts.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Bruzzese</b>		4. DATE OF DEATH Month Day Year <b>November 9 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-14-86</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railway Express</b>	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Mike Bruzzese</b>		14. MOTHER'S MAIDEN NAME <b>Concetta Zurjolo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <b>Michael J. Bruzzese</b>		Address <b>805 48th A ve.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacter - Intestinal Hemorrhage</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Cirrhosis of Liver</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 1, 1957</b> to <b>Nov 9, 1958</b> , that I last saw the deceased alive on <b>November 1, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Brainin M.D.</b>		ADDRESS (Street, city or town, state) <b>6124 Central Ave</b>	
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		DATE SIGNED <b>11/9/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 12, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		ADDRESS <b>300 4th st. N.E.</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

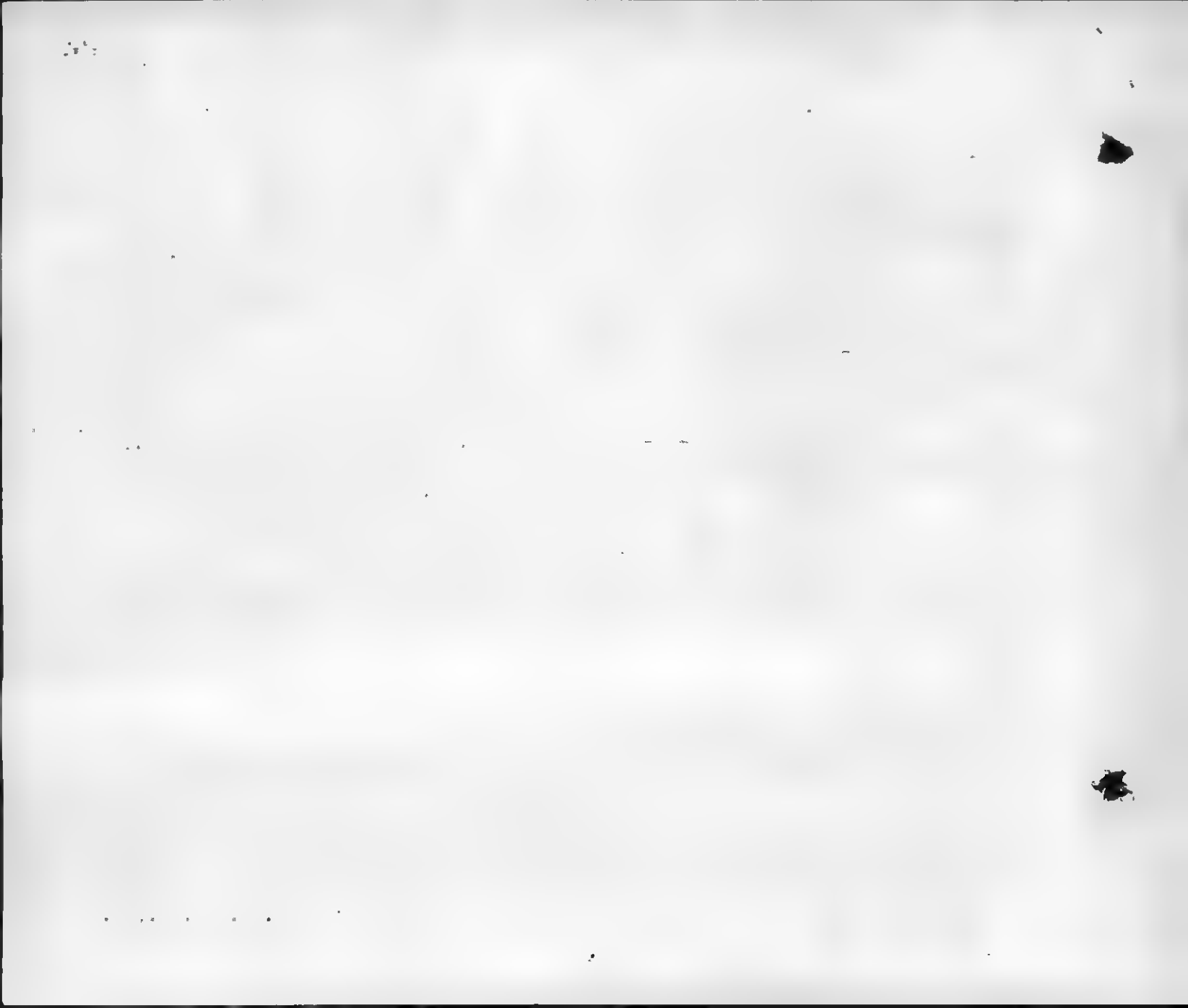
12794 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12807

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>College Park</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>College Park</b>	
c. LENGTH OF STAY IN 1b <b>3 months</b>		d. STREET ADDRESS <b>8914 Baltimore Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8914 Baltimore Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>TAPLEY</b> Middle <b>WILLIAM</b> Last <b>BRYANT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1st</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4th, 1867</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. UNDER 1 YEAR Months <b>11</b> Days <b>1</b>	11. UNDER 24 HRS Hours <b>1</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter Self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Repair</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Bryant</b>		14. MOTHER'S MAIDEN NAME <b>Clemetine Gutridge</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-18-4868D</b>	
17. INFORMANT <b>Taylor J. Bryant, 8914 Baltimore Ave.,</b>		Address <b>College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic renal disease</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. <b>19</b> p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/4/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Suitland Rd. Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>	
24b. REGISTRAR'S SIGNATURE		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12815

## CERTIFICATE OF DEATH

Reg. Dist. No.

12808

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHENEVY</u>	c. LENGTH OF STAY IN 1b <u>2 1/2 HRS.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X WOODLAWN (HYATTSVILLE PD)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGES GENERAL</u>		d. STREET ADDRESS <u>7103 GREENVALE PARKWAY</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>LOUIS</u> Middle <u>GREGORY</u> Last <u>CARON</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 12, 1892</u>
9. AGE (In years last birthday) <u>76</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTIFICIAL LIMB MFG.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VICTOR CARON</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	
17. INFORMANT <u>VELMA B CARON - 7103 GREENVALE PARKWAY</u>		Address <u>WOODLAWN, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>CEREBRAL HEMORRHAGE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO <u>GENERALIZED ARTERIO SCLEROSIS</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
27. I certify that I attended the deceased from <u>10 JUL 1956</u> to <u>11 MAR 1958</u> , that I last saw the deceased alive on <u>11 MAR 1958</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>THOMAS G. MALONEY</u> M.D. <u>4814-7157 CHX</u>		ADDRESS (Street, city or town, state) <u>W. W. CHAMBERS CO. RIVERDALE, MD.</u> DATE SIGNED <u>11 MAR 58</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS G. MALONEY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>11/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>COLMAR MARSH RD 606 Co. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO. RIVERDALE, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>J. L. S. Kenna</u>



Reg. Dist. No.

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE		Maryland b. COUNTY		PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Chesley		9 days		Cedar Heights		6418 L Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		PRINCE GEORGES GENERAL HOSPITAL							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH Month Day Year	
Esther		x		Garter				November 1 1958	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs.	
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		3/3/1909		49	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY			
Housewife				Virginia		United States			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
George Jackson		Lena Jackson							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address			
NO				Richard Carter Husband		Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		b. DUE TO		c. DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
442X		Uremia		b. Hypertensive Cardio-vascular renal		c. Deox		Years.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from October 28, 1958, to November 1, 1958, that I last saw the deceased alive on November 1, 1958, and that death occurred at 9:20 A. M. from the causes and on the date stated above									
ACTUAL SIGNATURE		M. D.		ADDRESS (Street, city or town, state)		DATE SIGNED			
Ronald S. Fleischer				5432 WUFFENS CIRCLE Rd		11/1/58			
PHYSICIAN'S NAME (Type)		RONALD S. FLEISCHER		17475VILLE, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
11-5-58		Woodlawn		Benning Rd SE, NE		106			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
J. S. Washington		467 N St NW		DATE		11/1/58			

VS A15 (4)  
15M 10/57

**TO HUSBAND OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.

**VS FURNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12861

## CERTIFICATE OF DEATH

Reg. Dist. No.

12810

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If instituting on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cottage City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3714-43rd Ave.</u>				d. STREET ADDRESS <u>3714-43rd Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Robert Peter Conlan</u>				4. DATE OF DEATH <u>Nov. 19th 1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1891</u>	9. AGE (In years last birthday) <u>67</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer, Retired U.S. Government</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Albany, New York</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>John Conlan</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Sweeney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>5/4/18-8/16/19</u>				16. SOCIAL SECURITY NO <u>Robert J. Conlan</u>			
17. INFORMANT <u>above</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>153.3</u> DUE TO <u>Gen. carcinoma atoxis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12-9-58</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma of sigmoid colon</u> DUE TO (c) <u>Metastasis</u>				<u>12-17-57</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>12-9-57</u> to <u>11/19-58</u> that I last saw the deceased alive on <u>11/19-58</u> , and that death occurred at <u>6:21 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>11/19/58</u>				DATE SIGNED			
ACTUAL SIGNATURE <u>George J. Hageage</u> M.D. <u>3717-38th</u>				PHYSICIAN'S NAME (Type) <u>George J. Hageage</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>			
24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12817

## CERTIFICATE OF DEATH

12811

Reg. Dist. No

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>			
c. LENGTH OF STAY IN 1b <b>13 days</b>				d. STREET ADDRESS <b>Box 15 A Route 1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George</b>				e. IS RES DENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lucile</b> Middle <b>Coplan</b> Last <b>Coplan</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>20</b> Year <b>1958</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-1909</b>		9. AGE (In years last birthday) <b>48 9 yrs</b>	IF UNDER 1 YEAR Months <b>11</b> Days <b>2</b> Hours <b>18</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CASHIER.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CAB Co.</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579 28 9987</b>		17. INFORMANT <b>BOX 15 A, ROUTE 1. MRS. IVY M GORMLEY. UPPER MARLBORO MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>6000</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Pyelonephritis.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 Nov 58</b> <b>1958</b> , to <b>17 Nov</b> <b>1958</b> , that I last saw the deceased alive on <b>19 Nov</b> <b>1958</b> , and that death occurred at <b>12-15 A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>William M. Dixon</b> M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/22/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>WASHINGTON NATIONAL CTM</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEORGES VO MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. H. [Signature]</b>				24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



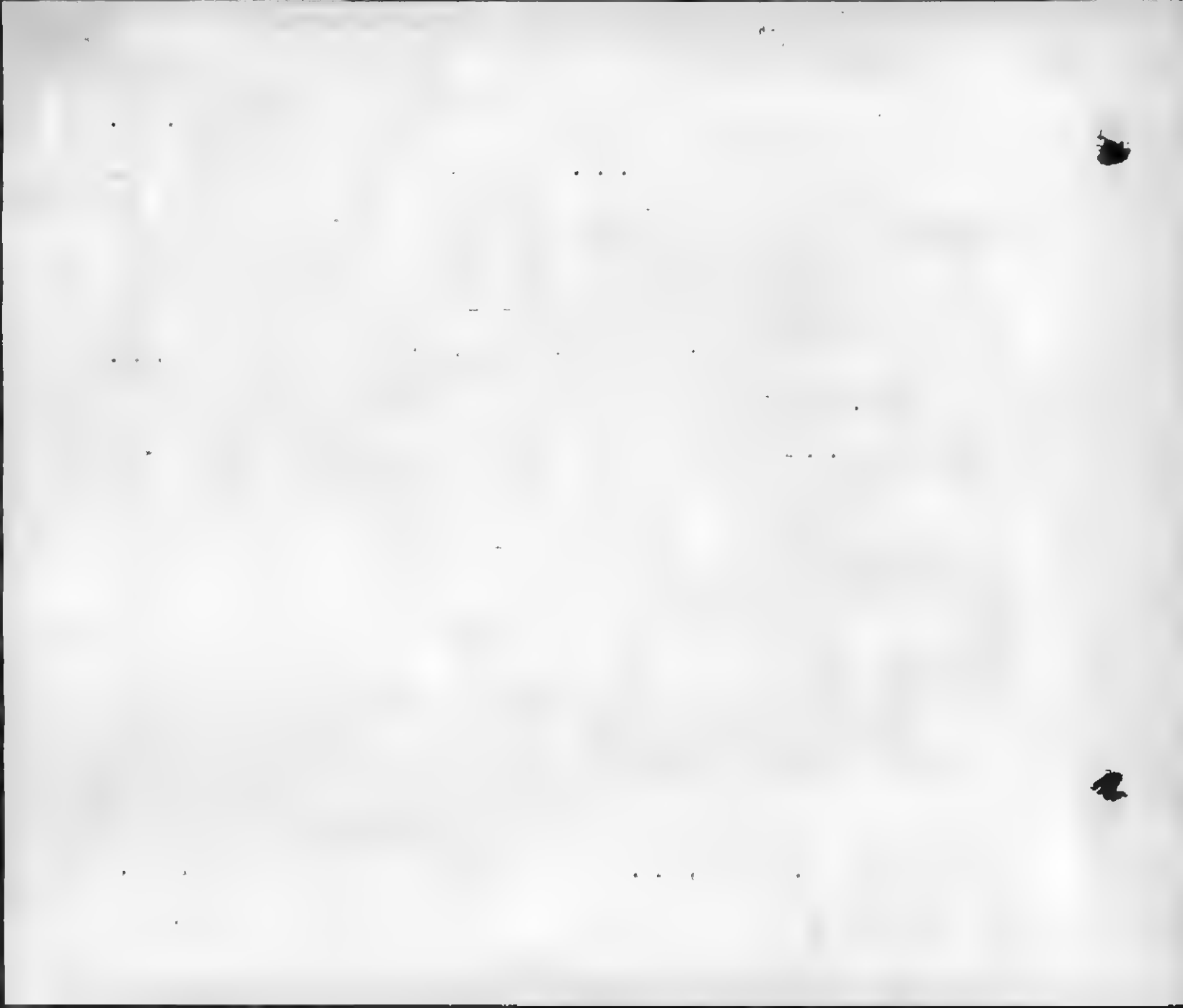
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FOR STATE  
HEALTH DEPT.

VS A15ME  
BM 2-57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12818 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12812

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3800 Bunker Hill Road</b>	
3. NAME OF DECEASED (Type or print) <b>James Thornton Cornwell</b>		4. DATE OF DEATH <b>November 30 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2-12-1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>30</b> Days <b>30</b> Hours <b>30</b> Min. <b>30</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Disabled Veteran</b>	
13. FATHER'S NAME <b>Edgar M. Cornwell</b>		14. MOTHER'S MAIDEN NAME <b>Annie Posey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes W.W. 1</b>		16. SOCIAL SECURITY NO. <b>W.W. 1</b>	
17. INFORMANT <b>Evelyn Tanner; same address as # 2.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>442X</b> DUE TO Conditions if any, which gave rise to immediate cause (b) <b>Cardiovascular renal disease</b> (c) <b>Cardiovascular renal disease</b> DUE TO cause lost (c) <b>Cardiovascular renal disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. M. Maloney</b>		DATE SIGNED <b>November 30, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. M. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Dec 3, 1958</b>		22b. DATE THEREOF <b>Dec 3, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>DEC 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. P. P.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

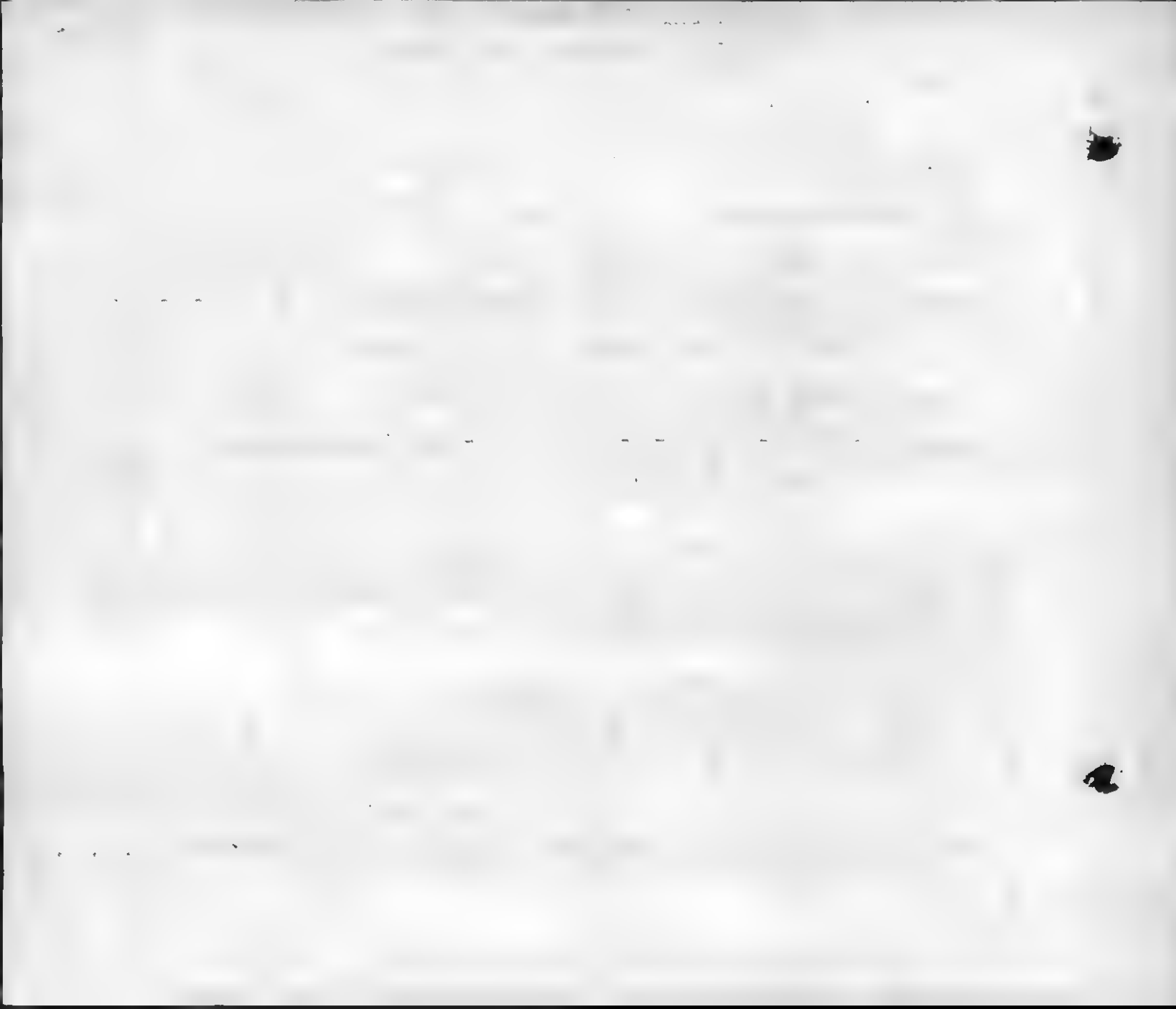
12862

## CERTIFICATE OF DEATH

12813

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Prince George</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>North Carolina</b> b. COUNTY <b>Unknown</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Andrews AF Base</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USAF Hospital, Andrews</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fayetteville</b>			
				f. STREET ADDRESS <b>5403 Dairy Road</b>			
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Leo</b> Last <b>Costello</b>				4. DATE OF DEATH Month <b>November</b> Day <b>17</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cau</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 14 1918</b>	
				9. AGE (In years last birthday) <b>39</b> yrs		IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min <b>-</b>	
				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US Air Force</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Air Force</b>	
				11. BIRTHPLACE (State or foreign country) <b>Colorado</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Patrick Martin Costello</b>				14. MOTHER'S MAIDEN NAME <b>unknown, Donohue</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>41-45 &amp; 50-53</b>				16. SOCIAL SECURITY NO <b>224-52-1851</b>		17. INFORMANT <b>Wife - Mrs Virginia Costello</b>	
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>470X</b> (c) <b>470X</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of Liver with Ascites</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. m.</b> Month <b>19</b> Day <b>19</b> Year <b>1958</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <b>17 Nov 58</b>		(County) (State)	
21. I certify that I attended the deceased from <b>24 Oct</b> , 19 <b>58</b> , to <b>17 Nov</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>16 Nov</b> , 19 <b>58</b> , and that death occurred at <b>0855a</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>17 Nov 58</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Bernard T Clowdus</b>				M.D. <b>USAF Hospital, Andrews</b>			
PHYSICIAN'S NAME (Type) <b>BERNARD CLOWDUS, CAPT, USAF (MD)</b>				<b>Andrews AF Base, Washington 25, D. C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WINNARD FUNERAL HOME</b>				ADDRESS <b>816 H ST. N.E. WASHINGTON 2 D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 19 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





12863

## CERTIFICATE OF DEATH

12814

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ACCOKEEK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ACCOKEEK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOX 360 ROUTE #1</u>		d. STREET ADDRESS <u>BOX 360 ROUTE #1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD LELAND DARLING</u>		4. DATE OF DEATH Month Day Year <u>NOV 27, 1958</u>	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 23, 1902</u>
9. AGE (In years last birthday) yrs <u>56</u>	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MARINE ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EMB. DAIRY</u>	11. BIRTHPLACE (State or foreign country) <u>GIRARD ILLINOIS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN GRAHAM</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WAR I.</u>	
16. SOCIAL SECURITY NO. <u>163-01-3461</u>		17. INFORMANT Address <u>Mrs. Sullivan R. DARLING ACCOKEEK, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Fibrosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Emphysema</u> DUE TO (c) <u>Cor Pulmonale</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I attended the deceased from <u>Jan 1953</u> to <u>Nov 27, 1958</u> that I last saw the deceased alive on <u>11-27, 1958</u> , and that death occurred at <u>4:05 P.M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <u>Eugene J. Y. [Signature]</u> M.D.		<u>20 Nov 1958</u>	
PHYSICIAN'S NAME (Type) <u>E. J. YERKOWITZ M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12-1-1958</u>	<u>Arlington</u>	<u>Brookside Hill, Prince George's</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. W. Chambers Co. Inc., Washington, DC</u>		24a. REC'D BY REGISTRAR <u>DEC 1 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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D  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12819  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12815

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN b <b>20 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tuxedo</b>		d. STREET ADDRESS <b>5200 Tuxedo Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie B. Davidson</b>				4. DATE OF DEATH Month Day Year <b>Nov. 18 1958</b>				5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Mar. 21, 1876</b>				9. AGE (In years last birthday) <b>82</b>				10. IF UNDER 1 YEAR Months Days Hours Min				11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Clerk</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>Theodore B. Lipscomb</b>				14. MOTHER'S MAIDEN NAME <b>Annie Barker</b>															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.				17. INFORMANT <b>Ewell Mohler</b>				Address <b>Same Address</b>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Renal Failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Chronic Coronary Artery Disease</b>				INTERVAL BETWEEN ONSET AND DEATH															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that I attended the deceased from <b>Oct. 29, 1958</b> to <b>Nov. 18, 1958</b> , that I last saw the deceased alive on <b>Nov. 18, 1958</b> , and that death occurred at <b>9:15 A. M.</b> from the causes and on the date stated above.																ADDRESS (Street, city or town, state) <b>1726 Eye St., N.W.</b>				DATE SIGNED <b>Washington, D.C.</b>															
ACTUAL SIGNATURE <b>Saul Schwartzback</b>				M.D. <b>Dr. Saul Schwartzback</b>				PHYSICIAN'S NAME (Type) <b>Dr. Saul Schwartzback</b>				22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov. 21, 1958</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Maryland.</b>											
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>				24a. REC'D BY REGISTRAR <b>NOV 20 '58</b>				24b. REGISTRAR'S SIGNATURE <b>C. A. H. H.</b>																							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12820 CERTIFICATE OF DEATH

12816

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o STATE <u>Maryland</u> b COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Luther Robert Dowden</u>				4. DATE OF DEATH Month Day Year <u>Nov 11 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 3 1881</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Charlie Dowden</u>				14. MOTHER'S MAIDEN NAME <u>Ida Virginia Thayne</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Mr. Esther V. Sullivan (Chesley, Md.)</u>			
17. INFORMANT <u>Mr. Esther V. Sullivan (Chesley, Md.)</u>				Address <u>3012 Laurel Ave</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> DUE TO (b) <u>Pat t.b. (c.h.)</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>4 1/2 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov 6</u> , 19 <u>57</u> , to <u>Nov 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>58</u> , and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.							
ACTUAL <u>E. R. Fenton</u> M.D. <u>1801 Eye St NW</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Nov 6 DE</u>			
PHYSICIAN'S NAME (Type) <u>E. R. Fenton</u>				<u>Wash 6 DE</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Warrington</u>		22d. LOCATION (City, town, or county) (State) <u>Warrington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. W. Lees</u> ADDRESS <u>Wash D. C.</u>				24a. REC'D BY REGISTRAR <u>NOV 13 58</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur J. Thane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Prince Georges		Cheverly		10 hours		Prince Georges General Hospital			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH	
Susan				Dowling				Month Day Year November 5 19 58	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8/9/05		53 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife				Georgia		United States			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Sidney D. Macdonald		Nancy Kendley							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				George Dowling Husband		Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTRA CEREBRAL hemorrhage		INTERVAL BETWEEN ONSET AND DEATH		24 hrs	
443X		DUE TO		(b) HYPERTENSIVE CARDIOVASCULAR DISEASE					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
November 4, 1958						3503 PENNSYLVANIA		11/5/58	
21. I certify that I attended the deceased from November 4, 1958, to November 5, 1958, that I last saw the deceased alive on November 5, 1958, and that death occurred at 9:45 A. M. from the causes and on the date stated above		ACTUAL SIGNATURE		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED	
Norman Donat Breaux						3503 PENNSYLVANIA		11/5/58	
PHYSICIAN'S NAME (Type)		NORMAN DONAT BREAUX		M.D.		INT RAINIER MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
Burial		11/7/1958		Washington Nat		3822 Ave. Va			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Robert A. Mattingly		Wash. D.C.		NOV 10 1958		J. H. H. H. H.			

**O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**O FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12864

## CERTIFICATE OF DEATH

12818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glennedale, Maryland</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glennedale Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>William</b> Last <b>Duley</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Freight Conductor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	11. BIRTHPLACE (State or foreign country) <b>U S A</b>
13. FATHER'S NAME <b>Cornelius Duley</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>Mrs. Mary M Duley</b>		Address <b>Glennedale, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>year</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1950</b> to <b>Nov. 2, 1958</b> , that I last saw the deceased alive on <b>Nov. 1, 1958</b> , and that death occurred at <b>9:00</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. James Kurtz</b> M.D.		ADDRESS (Street, city or town, state) <b>R. B. D. Bowie Md.</b>	
PHYSICIAN'S NAME (Type) <b>H. James Kurtz</b>		DATE SIGNED <b>11/2/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 5, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		24a. REC'D BY REGISTRAR <b>NOV 6 '58</b>	
ADDRESS <b>Hyattsville, Maryland.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

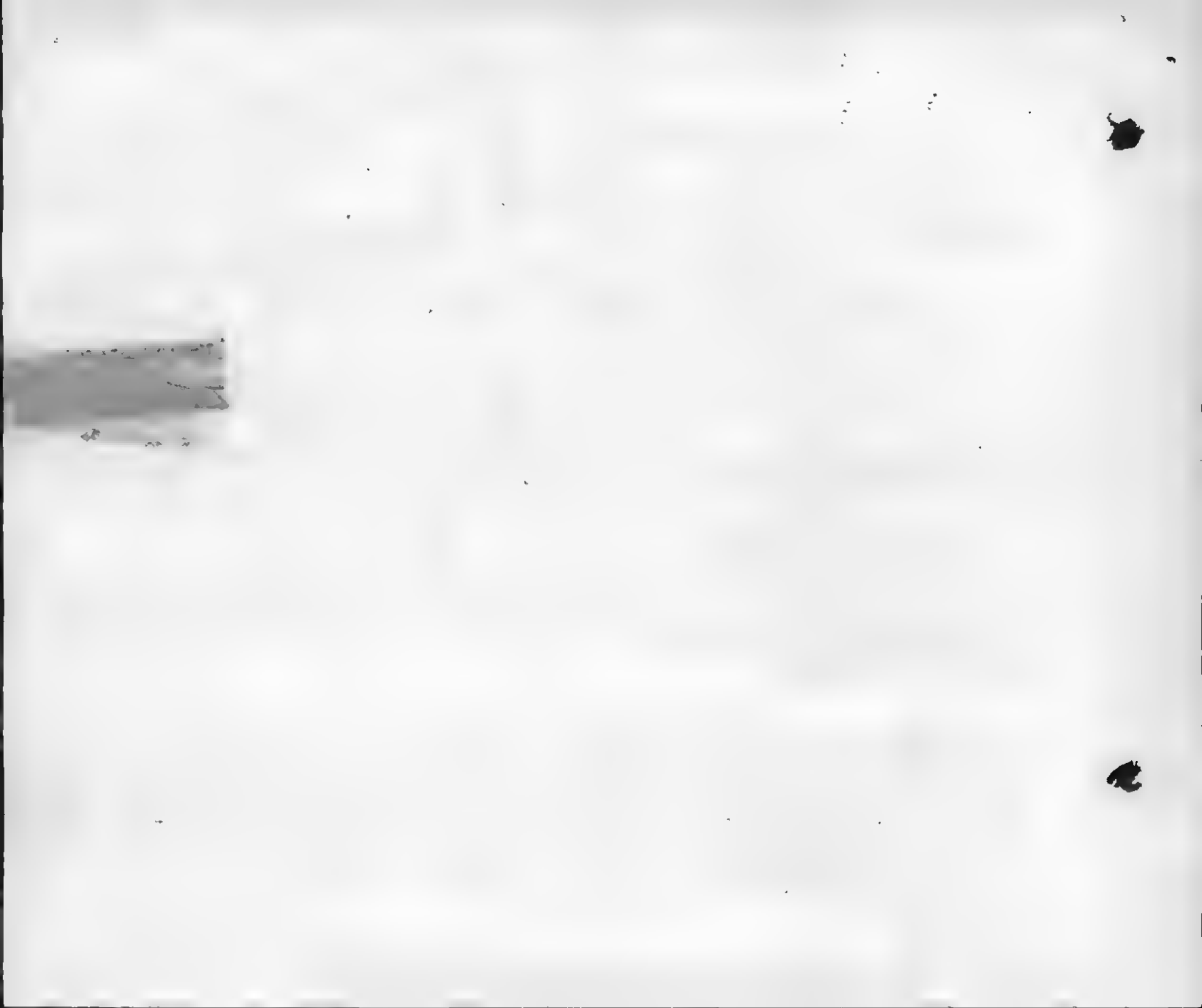


12822

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		d. STREET ADDRESS <b>3613 Centre Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Boy</b> Last <b>Duran</b>		4. DATE OF DEATH Month <b>November</b> Day <b>5</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 2, 1958</b>
9. AGE (In years last birthday) yrs. <b>3</b> Months <b>7</b> Days <b>45</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>PETER DURAN</b>		14. MOTHER'S MAIDEN NAME <b>Elsie Duran TIPPETT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Elsie</b>		Address <b>Mother Address Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>776 X Prematurely</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 2, 19 58</b> , to <b>November 5, 19 58</b> , that I last saw the deceased alive on <b>November 5, 19 58</b> , and that death occurred at <b>11 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William Brainin</b>		ADDRESS (Street, city or town, state) <b>6124 Central Ave</b>	
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>		DATE SIGNED <b>11/6/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE OF REMOVAL <b>11/8/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>mt olive</b>	22d. LOCATION (City, town, or county) (State) <b>Washington DC</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Esq</b>		ADDRESS <b>517 11th St SE</b>	
24a. REC'D BY REGISTRAR <b>NOV 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Howard</b>	



12823

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12820

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>	
c. LENGTH OF STAY IN 1b <u>1 Week</u>		d. STREET ADDRESS <u>Missouri Avenue</u>	
3 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>			
4 NAME OF DECEASED (Type or print) <u>Ernest G. Enslow</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jul 30, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. &amp;</u>	
13. FATHER'S NAME <u>Thomas Worthington Enslow</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kendall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-01-796</u>	
17. INFORMANT <u>May E. Hodges</u>		Address <u>5641-11 Allentown Rd</u> <u>Washington 23, DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>Nov 11, 1958</u>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>	22d. LOCATION (City, town, or county) (State) <u>Southland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Seniors Bros</u>		24a. REC'D BY REGISTRAR <u>1661-9d Hoped</u>	
24b. REGISTRAR'S SIGNATURE <u>Frank DC</u>		DATE <u>NOV 13 '58</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

12821

VS A15 (4)  
ISM 10/57





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12865

## CERTIFICATE OF DEATH

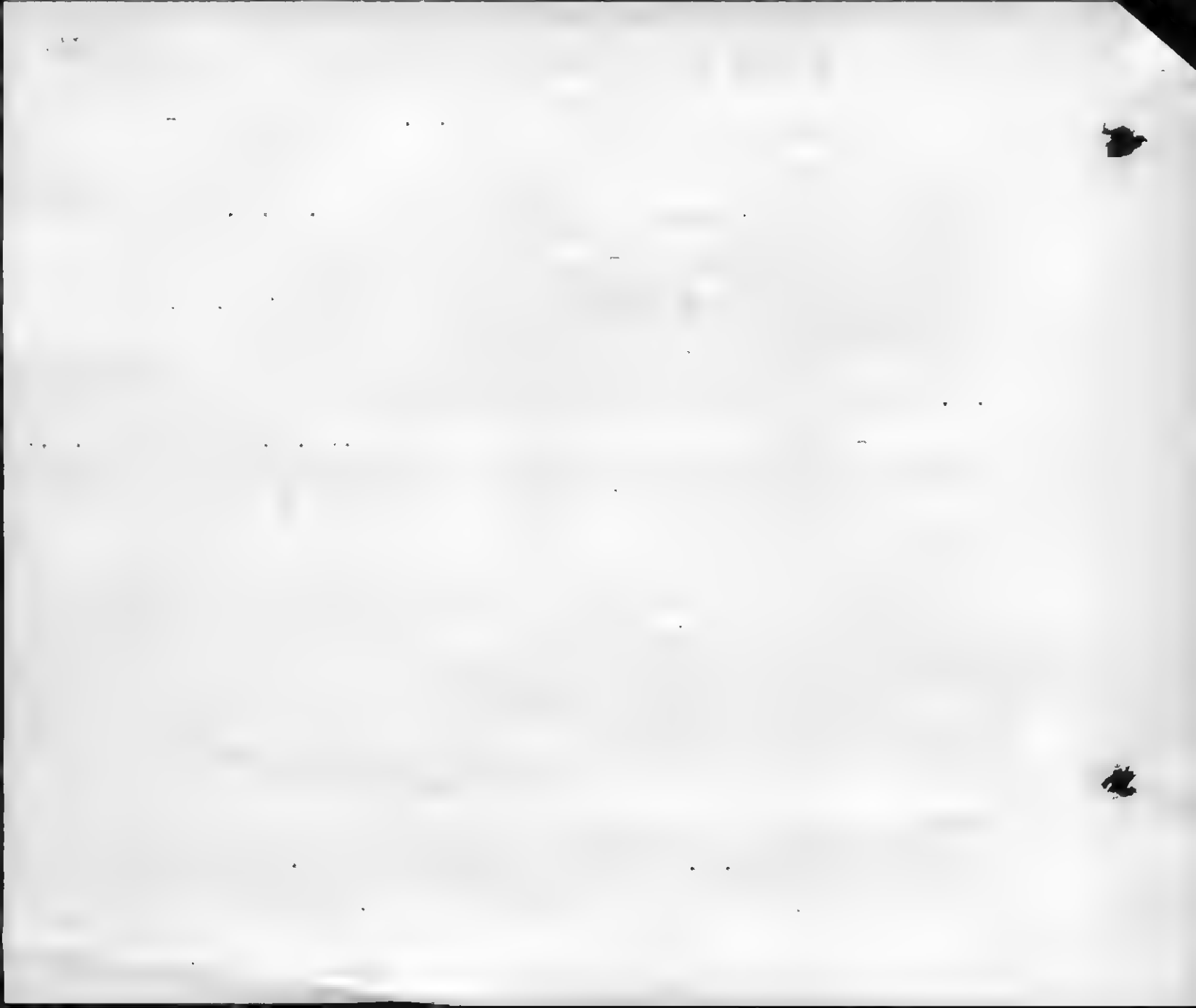
## Reg. Dist. No. 12822

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY _____									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>			c. LENGTH OF STAY IN 1b <u>6 months &amp; 19 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>3451 17th St., N. W.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Alice</u> Middle <u>-</u> Last <u>Finley</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>28</u> Year <u>19 58</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/3/93 or 11/4/94</u>		9. AGE (In years last birthday) <u>64 or yrs</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13. FATHER'S NAME <u>F. L. Fossick</u>				14. MOTHER'S MAIDEN NAME <u>Mary O'Reilly</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Information secured through Chest Clinic, 14th and Upshur Sts., N. W., Washington, D. C., by Miss Myer, Public Health Nurse</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pneumonitis, right lung, etiology undetermined, with secondary infection bullous cyst</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>5/9</u> , 19 <u>58</u> , to <u>11/28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>58</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale Hospital</u> <u>11/28/58</u> PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u> <u>Glenn Dale, Md.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <u>11/28/58</u>			22c. NAME OF CEMETERY OR CREMATORY			22d. LOCATION (City, town, or county) (State) <u>Tusculum Alabama</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The S. H. Vines Co. 2901-14th St. N.W. D.C.</u>										24a. REC'D BY REGISTRAR DATE <u>DEC 2 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frown</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12866

CERTIFICATE OF DEATH

Reg. Dist. No.

12823

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kent Village</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENT VILLAGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7204 Hawthorne Street</u>		d. STREET ADDRESS <u>7204-HAWTHORNE STREET</u>	
3 NAME OF DECEASED (Type or print) First <u>AMY</u> Middle <u>Fitzgerald</u> Last <u>Fitzgerald</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 21, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS CRABTREE</u>		14. MOTHER'S MAIDEN NAME <u>PRISCILLA HARRISON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>MRS. BEFANCE MERCHANT</u>		Address <u>9407-1 WELLINGTON ST SEABROOK, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral vascular failure.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease.</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>8 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year <u>9:45 a.m.</u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I attended the deceased from <u>JUNE 1937</u> to <u>Nov. 8</u> , 1958, that I last saw the deceased alive on <u>11/6/58</u> , 19 <u>58</u> , and that death occurred at <u>1945A</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. H. Aschenbach</u>		ADDRESS (Street, city or town, state) <u>1844 Col Rd NW</u>	
PHYSICIAN'S NAME (Type) <u>E. H. Aschenbach</u>		DATE SIGNED <u>  </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>	22b. DATE THEREOF <u>12/12/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	22d. LOCATION (City, town, or county) (State) <u>Swindon, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>  </u>		ADDRESS <u>475 H-ST. NW</u>	24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12824

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>ANNE ARUNDEL</u>		2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>PENN.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PHILADELPHIA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Laurel Race Track</u>		d. STREET ADDRESS <u>101 S. 41ST. ST.</u>	
3 NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>J</u> Last <u>Flood</u>		4. DATE OF DEATH Month <u>11</u> Day <u>10</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 4, 1904</u>
9. AGE (in years last birthday) <u>54</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. POLICE</u>	
11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JOSEPH FLOOD</u>		14. MOTHER'S MAIDEN NAME <u>ANNA SWEENEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>JOSEPH R. FLOOD-3008 N. 24th-Harrisburg Pa</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>4:20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Residential</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>William V. Givett</u>		DATE SIGNED <u>11-11-58</u>	
EXAMINER'S NAME (Type)		M D CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Phila. Penn.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 17 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12867

CERTIFICATE OF DEATH

12825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. COUNTY <u>Prince Georges</u> MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Michigan Park Hills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Michigan Park Hills</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5418-15th Place</u>		d. STREET ADDRESS <u>5418-15th Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Palma</u> Middle <u>Gallo</u> Last <u>Gallo</u>		4. DATE OF DEATH Month <u>11</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1897</u> 61 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Italy</u>	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis</u>		14. MOTHER'S MAIDEN NAME <u>Renebia</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>2704-Parsons Ave.</u>	
17. INFORMANT <u>Theresa DeBarnio</u> Address <u>2704-Parsons Ave. Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO		<u>3 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/17</u> , 19 <u>57</u> , to <u>11/24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/17</u> , 19 <u>58</u> , and that death occurred at <u>1:10</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Trozzo Jr.</u> M.D. <u>1840 Michigan Ave NE.</u>		DATE SIGNED <u>11/24/58</u>	
PHYSICIAN'S NAME (Type) <u>FRANK M. TROZZO</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	22d. LOCATION (City, State, and County) <u>Hyattsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home Inc.</u>		24a. REC'D BY REGISTRAR <u>NOV 26 58</u>	
ADDRESS <u>Mt. Rainier Md.</u>		24b. REGISTRAR'S SIGNATURE <u>James S. [unclear]</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12825

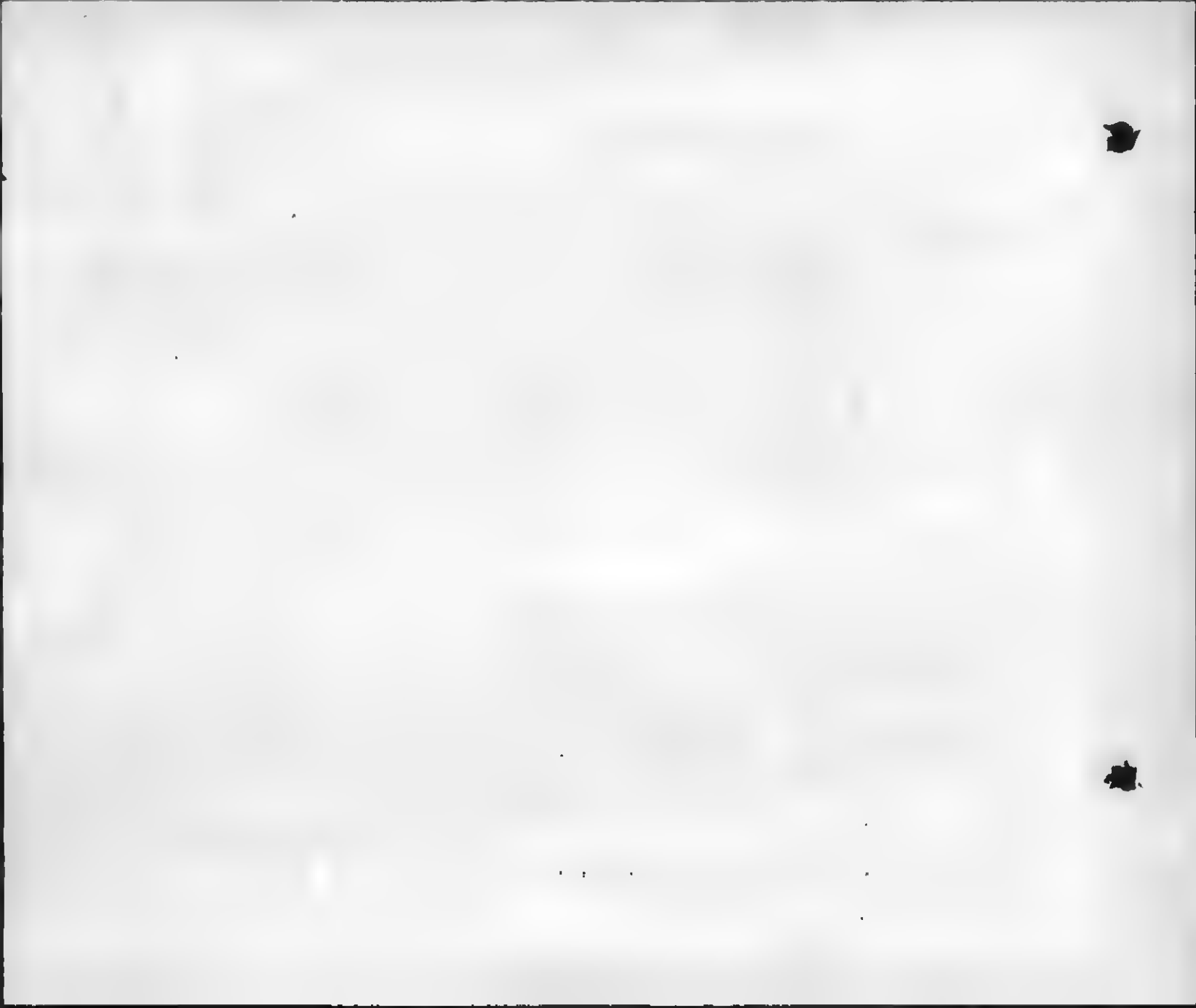
## CERTIFICATE OF DEATH

Reg. Dist. No. 12826

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Nathaly Lynn Garber</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>23</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 Nov 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>1</b> IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S..A</b>	
13. FATHER'S NAME <b>James H Garber</b>		14. MOTHER'S MAIDEN NAME <b>Jean Gibson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anomaly of central nervous system</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>22 Nov.</b> , 19 <b>58</b> , to <b>23 Nov.</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>23 Nov 1958</b> , 19 <b>58</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Robert S. McGeney</b> M.D.		ROBERT S. MCGENEY, M.D. 402 MAIN ST. LAUREL, MD.	
PHYSICIAN'S NAME (Type) <b>Dr. Robert McGeney, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>11/25/58</b>	<b>Harison Cemetery</b>	<b>Harison Co. Tenn.</b>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. FILED BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<b>Dr. Wm. Danielson</b>		<b>1 '58</b>	<b>Arthur S. Frank</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove cover papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

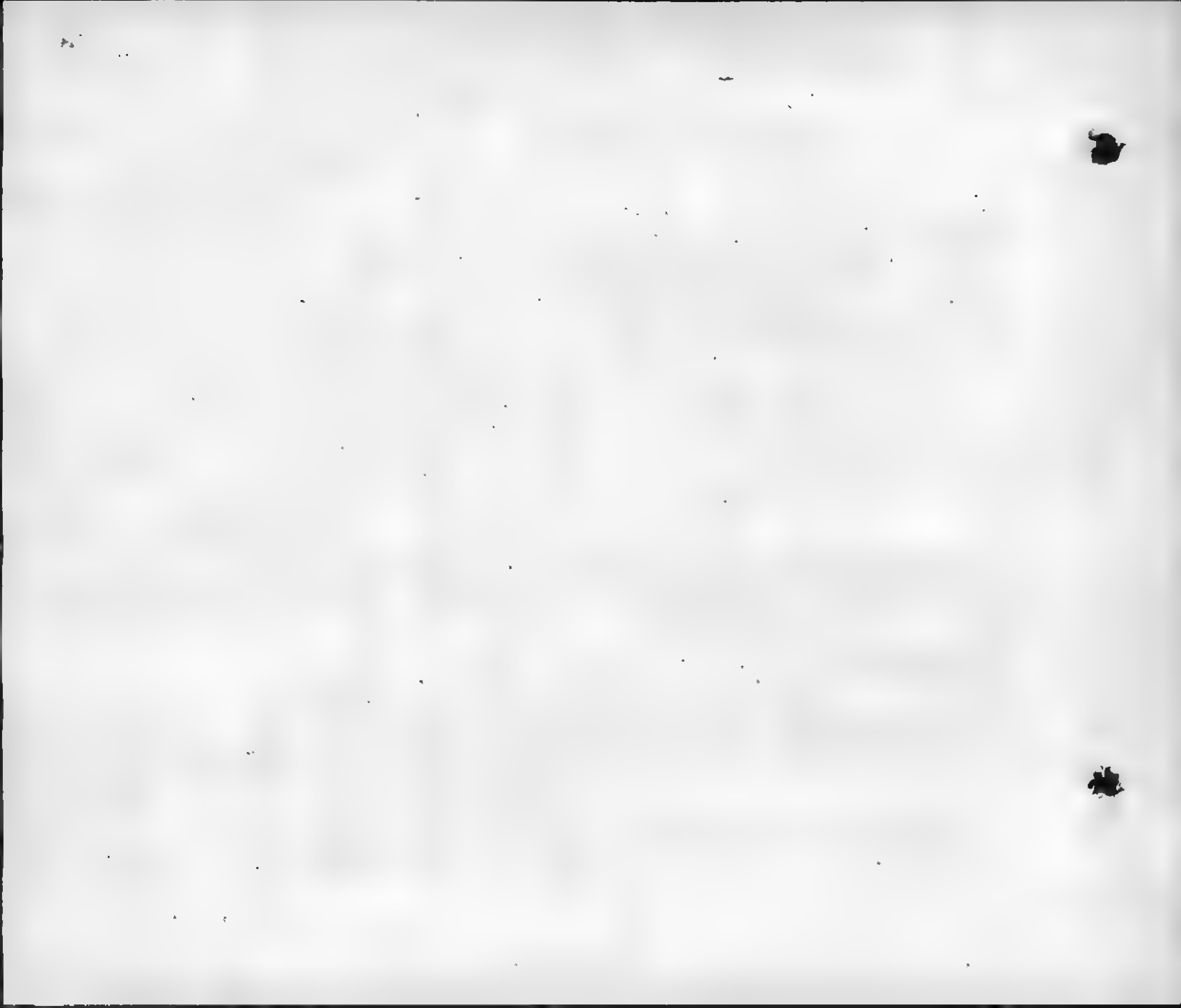
12826 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12827

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherley</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale</u>	
c. LENGTH OF STAY IN 1b <u>11 days</u>		d. STREET ADDRESS <u>5415 Quantona St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Kenneth Leon Gordon</u>		4. DATE OF DEATH <u>Nov 9 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27, 1938</u>
9. AGE (in years last birthday) <u>20</u> yrs		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTH PLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Max Gordon</u>		14. MOTHER'S MAIDEN NAME <u>Thelma Mcneade</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>102-Subby Pl</u>	
17. INFORMANT <u>Mr. Lily Gordon</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u>		DUE TO (b) <u>Fracture of base of skull</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Driver of auto that ran off road and struck a person</u>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Driver of auto that ran off road and struck a person</u>	
20c. TIME OF INJURY Month, Day, Year <u>Nov 9 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Antlers Rd</u>		20f. CITY OR TOWN (County) (State) <u>Antlers P. O. Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. Boyd</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov 9, 1958</u>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 12, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Maryland.</u>	
24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		DATE <u>NOV 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

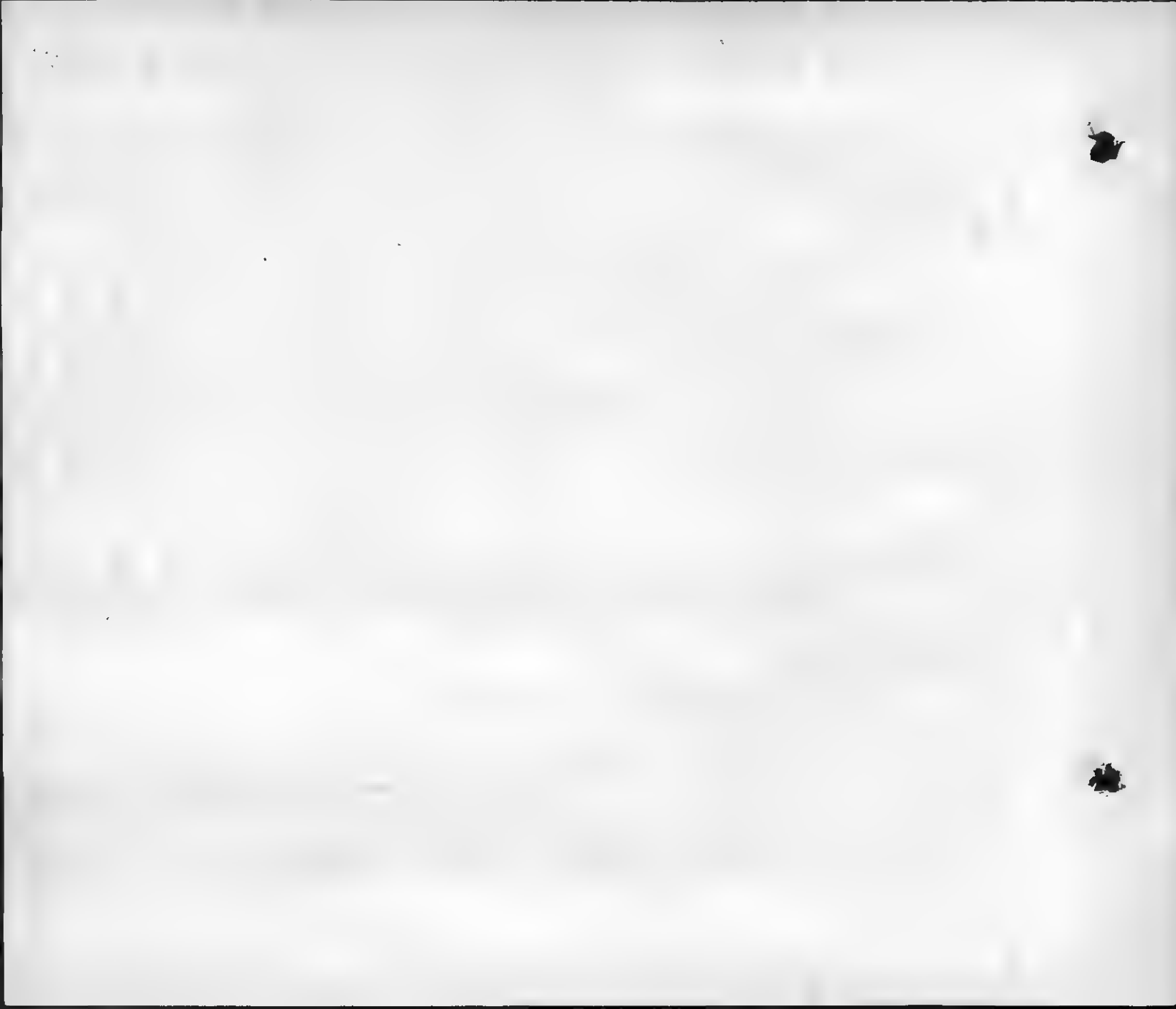
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12868

## CERTIFICATE OF DEATH

Reg. Dist. No. 12828

1. PLACE OF DEATH o COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>DISTRICT OF COLUMBIA</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AFB BASE</u>				c. LENGTH OF STAY IN 1b <u>—</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>QBAF HOSPITAL, ANDREWS</u>				d. STREET ADDRESS <u>15846 26th AVENUE S.E.</u>			
3. NAME OF DECEASED (Type or print) First, Middle, Last <u>STEPHEN MARTIN GOSSEN</u>				4. DATE OF DEATH Month, Day, Year <u>NOVEMBER 18 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>NA</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 18, 58</u>	9. AGE (In years last birthday) yrs <u>—</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>10</u> Hours <u>20</u>		IF UNDER 24 HRS Min <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NA</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA</u>		11. BIRTHPLACE (State or foreign country) <u>USAF HOSP ANDREWS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES M GOSSEN</u>				14. MOTHER'S MAIDEN NAME <u>HELEN I. SANDERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NA</u> (If yes, give war or dates of service) <u>NA</u>		16. SOCIAL SECURITY NO. <u>NA</u>		17. INFORMANT <u>JAMES M. GOSSEN</u> Address <u>FATHER - 5846-26th AVE S.E.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neonatal asoxia</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Abruptio Placentae</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>18 Oct</u> , 19 <u>58</u> , to <u>18 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>18 Oct</u> , 19 <u>58</u> , and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>18 NW 58</u> DATE SIGNED <u>18 Oct 58</u>							
ACTUAL SIGNATURE <u>Marvin S. Eiger</u> M.D.				ADDRESS <u>USAF Hosp. Andrews</u>			
PHYSICIAN'S NAME (Type) <u>MARVIN S. EIGER, CAPT, USAF(MD) ANDREWS AFBASE, WASH. 25, D.C.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 24 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RINALDI FUNERAL HOME</u>				ADDRESS <u>816 H ST. N.E. WASH. 2, DC</u>		24a. REC'D BY REGISTRAR <u>NOV 21 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifford E. K.</u>			



Reg. Dist. No. 12829

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If infirmity: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. LENGTH OF STAY IN 1b <b>12 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>5504 QUINCY ST</b>			
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>-</b> Last <b>GUNSON</b>				4. DATE OF DEATH Month <b>NOV</b> Day <b>14</b> Year <b>1958</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 10, 1875</b>	
9. AGE (In years lost birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON DC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>UNKNOWN</b>				16. SOCIAL SECURITY NO. <b>579-14-0032</b>			
17. INFORMANT <b>DOROTHY SPARTA</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>3 YRS</b>			
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>				20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>			
21. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				22. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
23. 20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>a. m.</b> p. m. <b>p. m.</b>				24. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
25. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				26. 20f. (City or town) (County) (State)			
27. 21. I certify that I attended the deceased from <b>JAN 1, 1955</b> to <b>NOV 14, 1958</b> , that I last saw the deceased alive on <b>NOV 14, 1958</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.				28. ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DR. NOV 14, 1958</b>			
29. ACTUAL SIGNATURE <b>SAMUEL J. N. SUGAR</b> M.D.				30. PHYSICIAN'S NAME (Type) <b>M. J. CAINIER, MD</b>			
31. 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				32. 22b. DATE THEREOF <b>11/18/58</b>			
33. 22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>				34. 22d. LOCATION (City, town or county) (State) <b>Shirland Ind.</b>			
35. 23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co Inc</b>				36. 24a. REC'D BY REGISTRAR <b>NOV 18 '58</b>			
37. 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>				38. 24c. REGISTRAR'S SIGNATURE <b>Arthur S. Finner</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

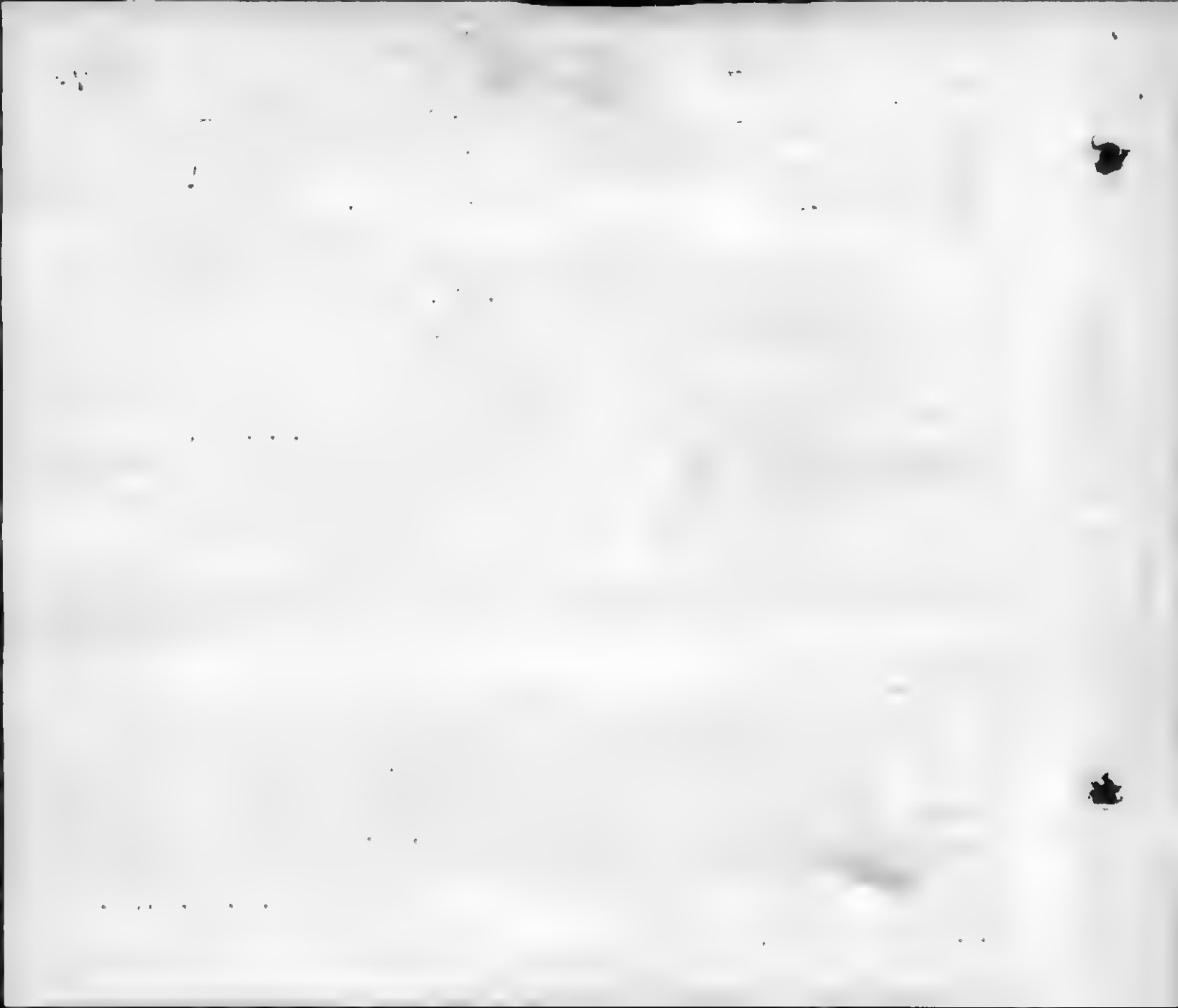
12869

CERTIFICATE OF DEATH

Reg. Dist. No. 12831

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillside</b>				c. LENGTH OF STAY IN 1b <b>23 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1222--64th Ave.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MOLLIE ELLEN HALE</b>				4. DATE OF DEATH Month Day Year <b>November 3rd, 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 16th, 1868</b>	
9. AGE (In years last birthday) <b>90 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Frank Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Mirah Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No None</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Lee Hale, 534 Lebaum St. S.E. Wash. DC</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis coronary arteria</b> DUE TO (c) <b>10 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>12-53</b> 19____, to <b>12-2-95</b> 19____, that I last saw the deceased alive on <b>Nov. 30, 1958</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3404 Cheverly Avenue, Cheverly, Md.</b> DATE SIGNED <b>11/3/1958</b>							
ACTUAL SIGNATURE <b>John Kehoe</b> M.D.							
PHYSICIAN'S NAME (Type) <b>John Kehoe</b>							
22a. BURIAL, CREMATION, REMOVA; (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/6/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Rd. Pr. Geo. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Huns</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12870

## CERTIFICATE OF DEATH

12832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>3400 Holmead Pl., N.W. #3</b>	
3. NAME OF DECEASED (Type or print) First <b>Magdalene</b> Middle <b>-</b> Last <b>Harris</b>		4. DATE OF DEATH Month <b>11</b> Day <b>27</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>legally separated</b>	8. DATE OF BIRTH <b>12/22/22</b>
9. AGE (In years last birthday) <b>35</b> yrs		10. IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b> Hours <b>-</b> Min <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mr. Helen Dapkus Bethesda, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis McBride</b>		14. MOTHER'S MAIDEN NAME <b>Phyllis Potter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO <b>Atherosclerosis of Hypertensive Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart Disease</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b> <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/21</b> , 19 <b>58</b> , to <b>11/27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/26</b> , 19 <b>58</b> , and that death occurred at <b>3:20 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Moe Weiss</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Glenn Dale Hospital 11/27/58</b>	
PHYSICIAN'S NAME (Type) <b>Moe Weiss, M. D.</b>		<b>Glenn Dale, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 6, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>	22d. LOCATION (City, town, or county) (State) <b>46 Benning Rd. Wash. D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas Jenkins</b>		ADDRESS <b>4504 Ga. Ave. N.W.</b>	
24a. REC'D BY REGISTRAR <b>DEC 30 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12827

CERTIFICATE OF DEATH

Reg. Dist. No.

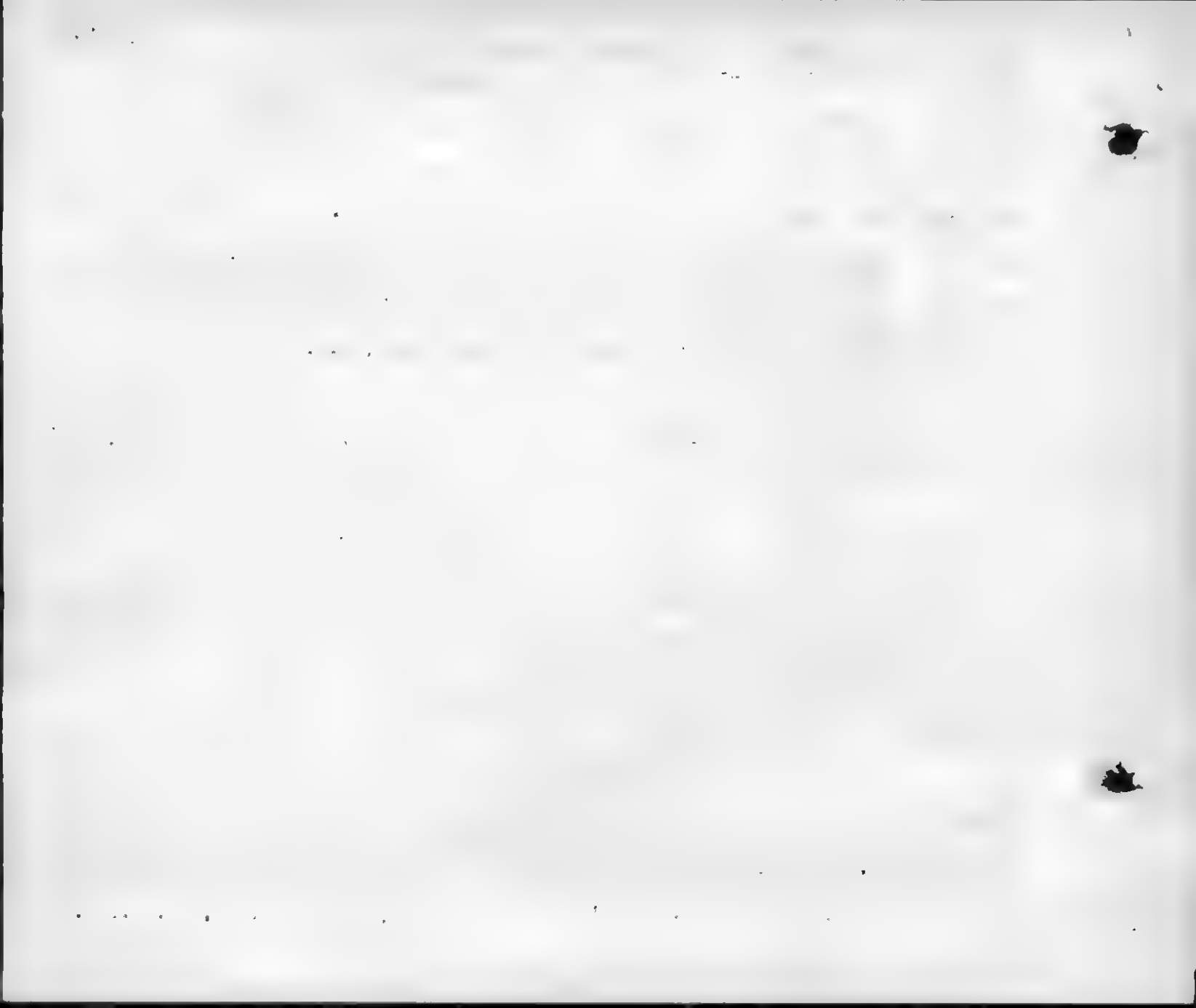
12833

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN b <b>6 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> d. STREET ADDRESS <b>1413 Oliver St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carl Bennett Hatcher</b>		4. DATE OF DEATH Month Day Year <b>Nov 24 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 20 1892</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Peoples Drug Stores Washington, D.C.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Bennett Hatcher</b>		14. MOTHER'S MAIDEN NAME <b>Mary Harriet Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>577-05-5300</b>	
17. INFORMANT <b>Carl B. Hatcher, Jr. 6312 Baltimore Ave.,</b>		Address <b>University Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>141.7</b> DUE TO <b>Generalized carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Cancer of tongue</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b> <b>1.7</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 1957</b> to <b>Nov 24 1958</b> , that I last saw the deceased alive on <b>Nov 24 1958</b> , and that death occurred at <b>9:51 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Till Bergeman</b>		ADDRESS (Street, city or town, state) <b>4314 Jackson St Hyattsville Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Till Bergeman</b>		DATE SIGNED <b>Nov 28 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 28th, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Church Cemetery, Ammdendale, Pr. Geo. Co., Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		ADDRESS <b>5801 Cleveland</b>	
24a. REC'D BY REGISTRAR <b>NOV 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

R.V. 1221



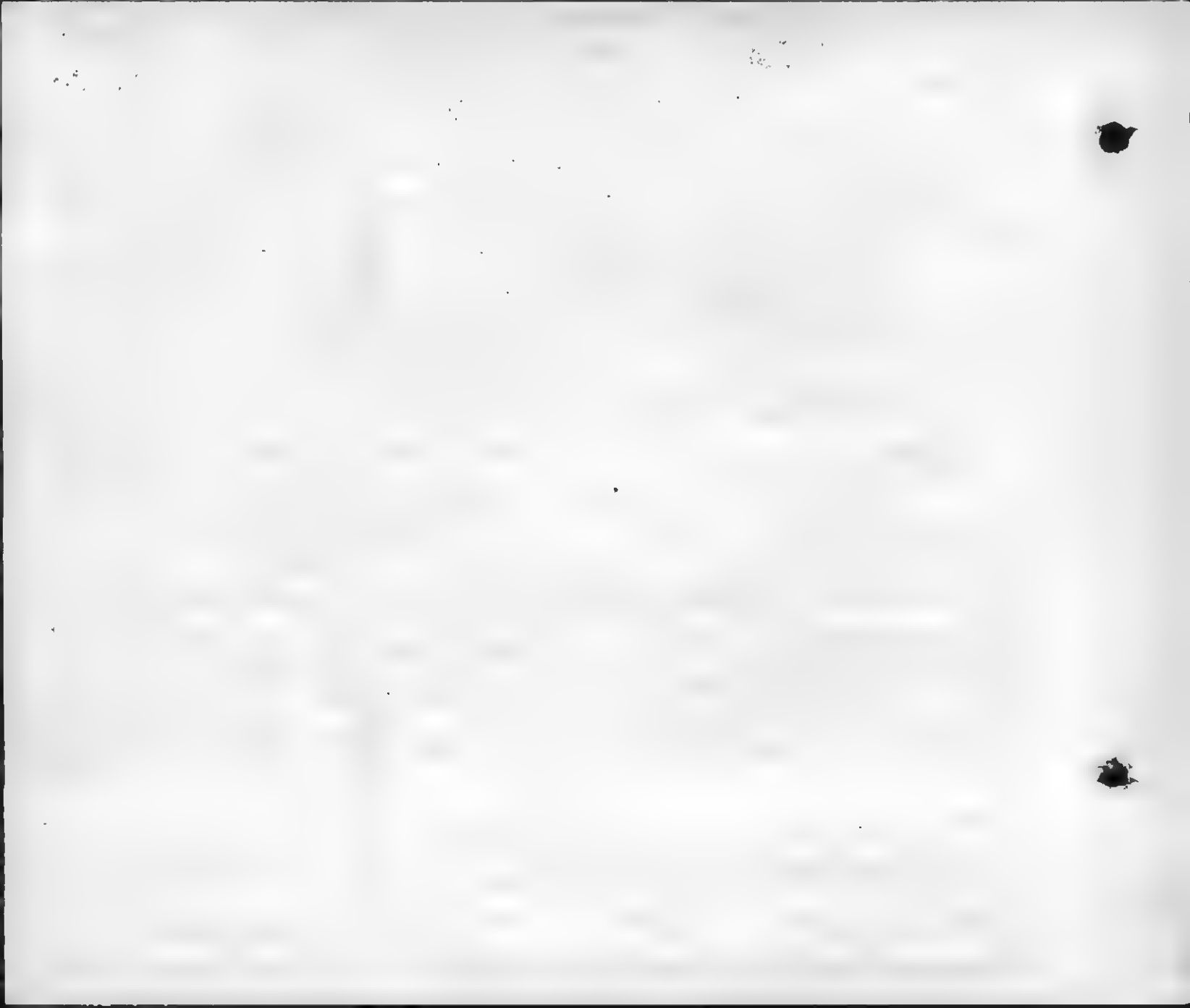
12828

CERTIFICATE OF DEATH

12834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) STATE <b>District of Columbia</b> COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b>				c. LENGTH OF STAY IN 1b <b>Adm. 3-2-58</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>LAUREL SANITARIUM</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELEANOR</b> Middle <b>H.</b> Last <b>HENRY</b>				4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 4-5-1886</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>7</b> Days <b>2</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JOHN L. HARRINGTON</b>				14. MOTHER'S MAIDEN NAME <b>EINA E. NEAR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>Unknown</b>		17. INFORMANT <b>HOSPITAL RECORDS LAUREL SANITARIUM</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Apoplexy 334</b> <b>334X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>cerebral arteriosclerosis</b> (c) <b>associated with psychotic reaction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>several years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>a. 9</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>June 7, 1956</b> to <b>Nov 2, 1958</b> , that I last saw the deceased alive on <b>Nov 2, 1958</b> , and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edith P. Klammer</b>				ADDRESS (Street, city or town, state) <b>LAUREL SANITARIUM</b>			
PHYSICIAN'S NAME (Type) <b>ERITA P. KRAMER</b>				DATE SIGNED <b>11-2-58</b>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-5-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cemt</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. H. H. H. H.</b>				24a. REC'D BY REGISTRAR <b>NOV 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. H. H.</b>	





**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12829** **CERTIFICATE OF DEATH**

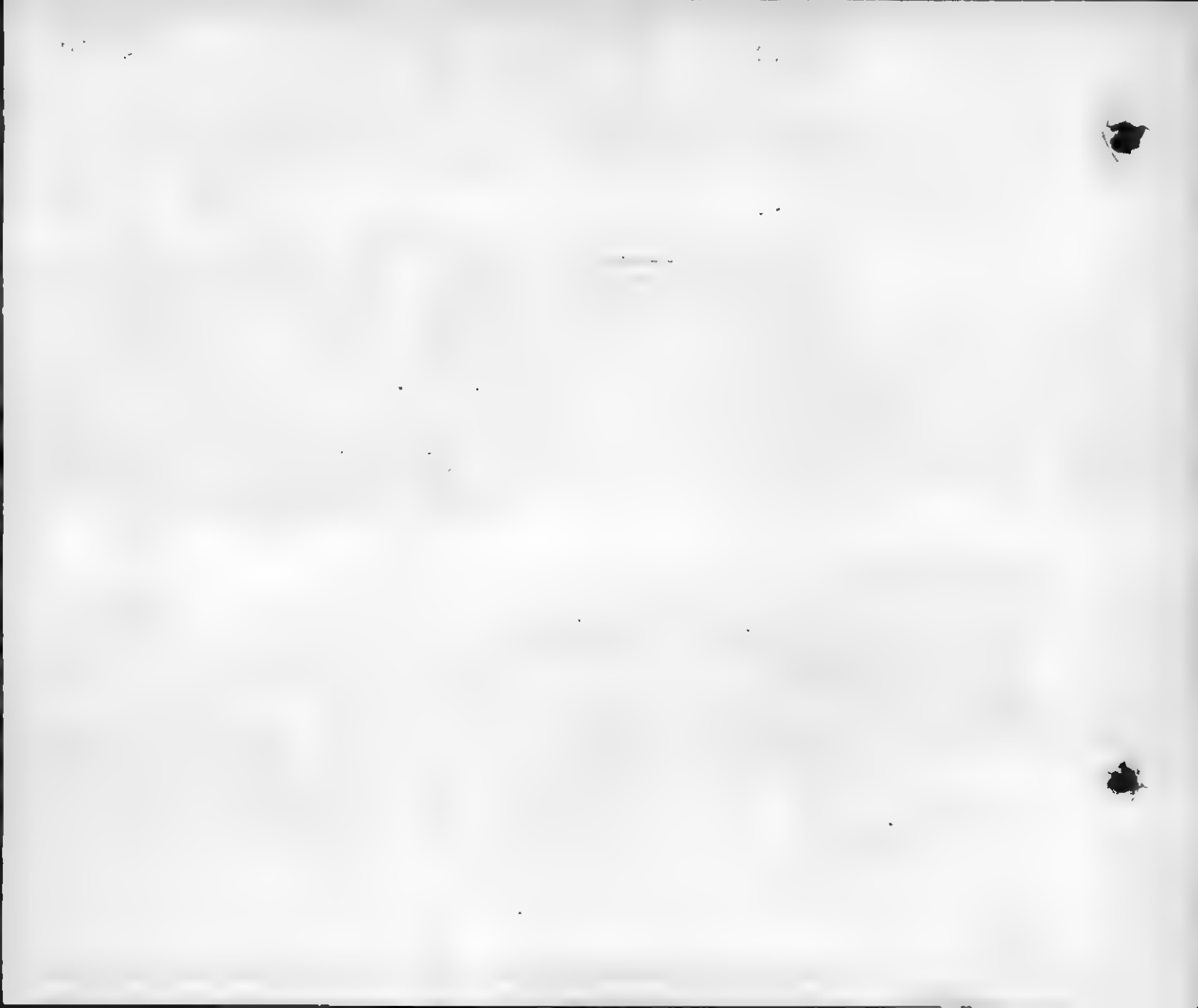
12835

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesley</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Hild</b> Last <b>Hild</b>				4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/18/83</b>	
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		10. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat Supply</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Meat</b>		11. BIRTHPLACE (State or foreign country) <b>Hungary</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>John Hild</b>				14. MOTHER'S MAIDEN NAME <b>Not Available</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Frances Hild</b> Address <b>address same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial insufficiency</b> DUE TO <b>uremia</b> DUE TO <b>Cardio Vascular Renal Disease</b> DUE TO <b>Prostatic Hypertrophy Benign</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Prostatic Hypertrophy Benign</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>10/21/58</b> , 19 <b>58</b> , to <b>11/14/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/14/58</b> , 19 <b>58</b> , and that death occurred at <b>12:50AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis B. Bachrach MD</b>				ADDRESS (Street, city or town, state) <b>915 St. N. W. Washington D. C.</b>			
DATE SIGNED <b>11/14/58</b>							
PHYSICIAN'S NAME (Type) <b>LOUIS, B. BACHRACH M.D</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Burtonsville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Arthur Walters, 254 Carroll Pl NW DC</b>				24a. REC'D BY REGISTRAR <b>NOV 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be attached with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

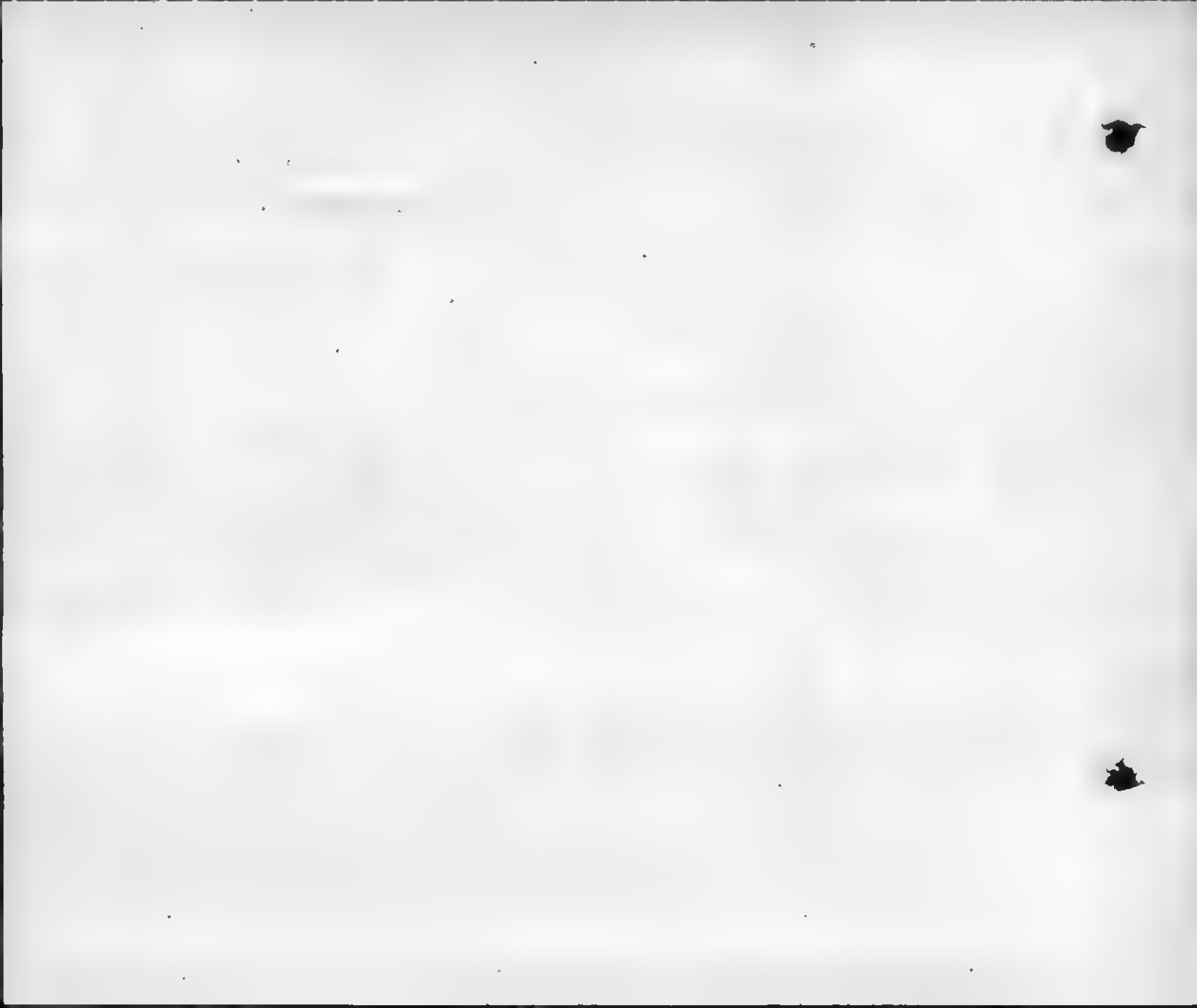


may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Medical Examiner's Office

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18													
Items 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100													
12871 CERTIFICATE OF DEATH 12836													
Reg. Dist. No.													
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND						2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights Md				c. LENGTH OF STAY IN 1b 39 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn Heights, Md.							
d. NAME OF HOSPITAL (If not in hospital, give street address) 8609 57th avenue						d. STREET ADDRESS 8609 57th avenue, ..				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mortimer C. Johnstone						4. DATE OF DEATH Month Day Year Nov 2, 1958							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 14, 1887		9. AGE (In years last birthday) 77 1/2 yrs		10. IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pressman				10b. KIND OF BUSINESS OR INDUSTRY newspaper		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.			12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME Robert B Johnstone						14. MOTHER'S MAIDEN NAME Mary E Graft							
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Lillian A Johnstone Berwyn Heights, Md;							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Arterio-sclerotic cardio-vascular disease DUE TO (c) Vascular disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 1958 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Oct 30, 1958, to Nov 2, 1958, that I last saw the deceased alive on Oct 30, 1958, and that death occurred at 7:30 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE W.L. ETIENNE M.D. ADDRESS (Street, city or town, state) 4713 Berwyn Rd, Colmar Manor, Md. DATE SIGNED Nov 3, 1958 PHYSICIAN'S NAME (Type) W.L. ETIENNE													
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				22b. DATE THEREOF Nov 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory				22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons						ADDRESS Hyattsville Maryland.			24a. REC'D BY REGISTRAR DATE NOV 6 '58		24b. REGISTRAR'S SIGNATURE Charles E. Harris		



1 **FOR STATE HEALTH DEPT.**

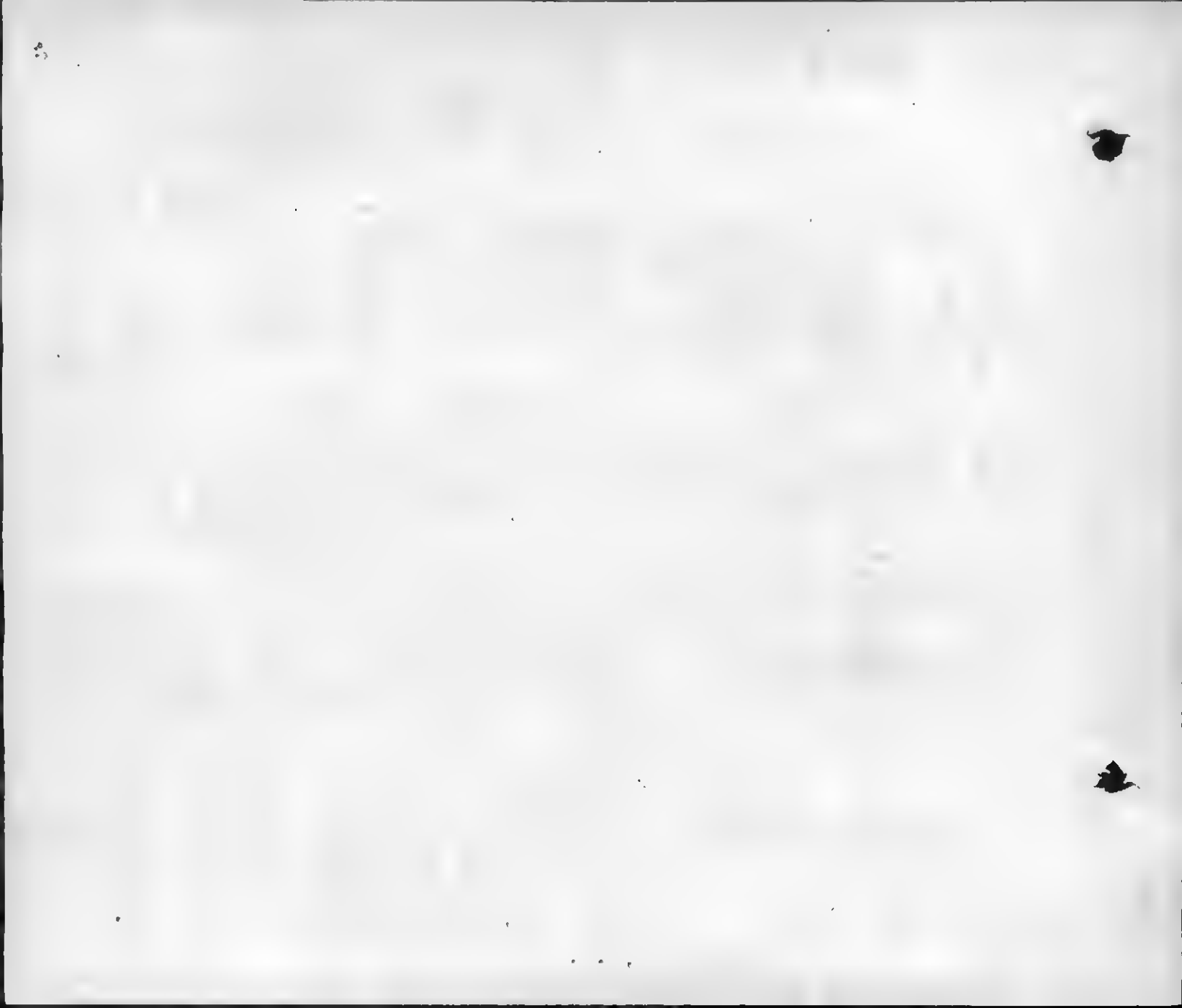
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12830 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District Col.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>		d. STREET ADDRESS <u>642 - L Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Cleveland James</u>		4. DATE OF DEATH <u>Nov-6-</u> 1958	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-94</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R-R-</u>	
11. BIRTH PLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Jones</u>		14. MOTHER'S MAIDEN NAME <u>Lore Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give branch or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u>253-20-025</u>	
17. INFORMANT <u>Willie Mae Jones, same address</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Acute congestive heart failure</u> DUE TO (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John J. Maloney</u>		DATE SIGNED <u>11-6-58</u>	
EXAMINER'S NAME (Type) <u>JOHN T MALONEY, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/12/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. McEntire</u>		24a. REC'D BY REGISTRAR <u>412 St. N.E.</u>	
24b. REGISTRAR'S SIGNATURE <u>412 St. N.E.</u>		DATE <u>NOV 11 1958</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12872 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dr. Robyns Office</u>		e. STREET ADDRESS <u>RED 2, Box 70 Walday Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Delinda Ann Jones</u>		4. DATE OF DEATH Month <u>November</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 25, 1958</u>
9. AGE (in years last birthday) <u>7</u> yrs. <u>15</u> Months <u>15</u> Days		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Harry Bernard Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elmer Munson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Harry B Jones</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		DATE SIGNED <u>Nov 9, 1958</u>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-11-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Piscataway, Md.</u>
23. GENERAL DIRECTOR'S SIGNATURE <u>Myrtle K. Ballis</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 12 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Myrtle K. Ballis</u>		ADDRESS <u>4339 Huntol, N.E.</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12873 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

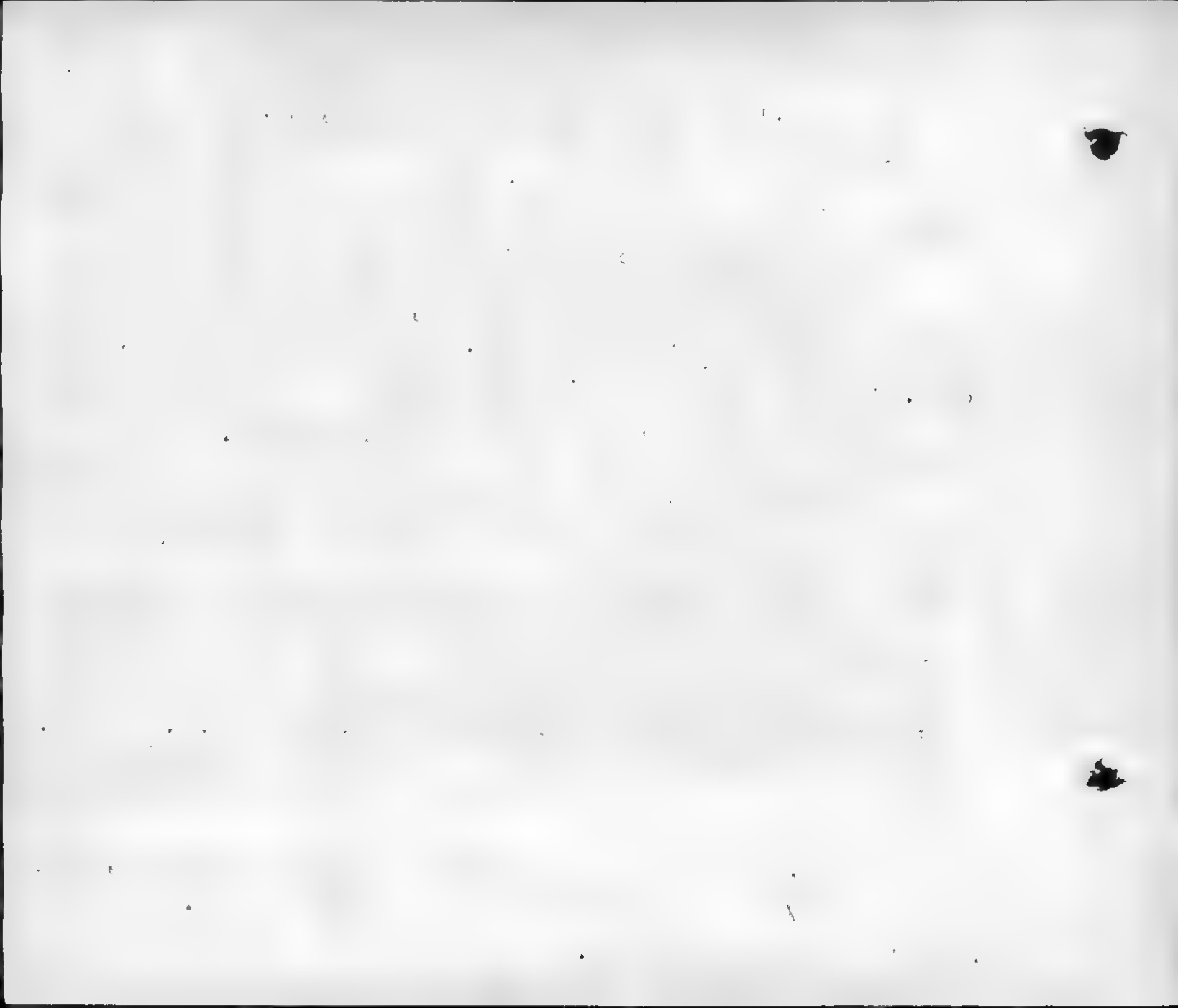
12833

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George's</b> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <b>Washington, D.C.</b> COUNTY	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <b>Accokeek</b>		c. LENGTH OF STAY IN 1b <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Gardiner Road</b>		e. STREET ADDRESS <b>424 3rd Street</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Bob</b> <span style="float: right;">First</span> <b>Lee</b> <span style="float: right;">Middle</span> <b>King</b> <span style="float: right;">Last</span>		<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>11</b> Year <b>1958</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>April 28, 1940</b>
<b>9. AGE</b> (In years last birthday) <b>18</b> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
<b>11. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b>		<b>12. BIRTHPLACE</b> (State or foreign country) <b>Va.</b>	
<b>13. FATHER'S NAME</b> <b>Oscar R. King</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Emma Pruett</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>Unk.</b>	
<b>17. INFORMANT</b> <b>Emma King (Mother)</b>		Address <b>Salem Va.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of the base of the skull, Crushed chest</b> (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) <b>Occupant of an auto that ran off the road, struck fixed object</b>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>11:20 PM 11/10/58</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>Gardiner Road</b>		<b>20f. (City or town) (County) (State)</b> <b>Accokeek P. G. Md.</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/></b>			
<b>ACTUAL SIGNATURE</b>  <b>EXAMINER'S NAME (Type)</b> <b>James I. Boyd</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>11/13/58</b>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Sherwood Burial Park</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Salem Va.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F. Gasch's Sons</b>		<b>ADDRESS</b> <b>Hyattsville, Md.</b>	
<b>24a. REC'D BY REGISTRAR</b> <b>NOV 14 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> 	

DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12831

Reg. Dist. No. 12840

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Chesley</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Green Dale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>		d. STREET ADDRESS <u>Northern Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Traft Rivett Jr</u>		4. DATE OF DEATH Month <u>11</u> - Day <u>10</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-33</u>
9. AGE (In years last birthday) <u>24</u> yrs		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Elec. generators</u>	
13. BIRTHPLACE (State or foreign country) <u>Maryland</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Robert Traft Rivett</u>		16. MOTHER'S MAIDEN NAME <u>Frances Elizabeth Smith</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes 1954-57</u>		18. SOCIAL SECURITY NO <u>214-30-2143</u>	
19. INFORMANT <u>Donna Jean Rivett - Same address</u>		20. ADDRESS <u>Same address</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage &amp; shock</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of skull</u> (c), stating the underlying cause last. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between Onset and Death</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Operator ran automobile in collision with a tree.</u>	
20c. TIME OF INJURY Month, Day, Year <u>4:30 p.m. 11-10-1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Pr. Geo - Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>		DATE SIGNED <u>11-10-58</u>	
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 14, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		ADDRESS <u>Hyattsville Maryland.</u>	
24a. REC'D BY REGISTRAR <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. E. R. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12832 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Maryland</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>		c. LENGTH OF STAY IN 1b <u>2009</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Rainier</u>		d. STREET ADDRESS <u>3814 - 31st St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harriet</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>14</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1880</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Helvin</u>				14. MOTHER'S MARDEN NAME <u>Patsy Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give no. or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01254</u>		17. INFORMANT <u>Frank Kleindienst - Same address</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 44 <u>Cardiovascular renal disease</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN T. MALONEY, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11-15-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-18-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Malloy's Funeral Home Inc.</u>				24a. REC'D BY REGISTRAR <u>3100-R.I. Ave.</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>				DATE <u>NOV 19 '58</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12874

## CERTIFICATE OF DEATH

## Reg. Dist. No. 12842

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews AFB</u> c. LENGTH OF STAY IN 1b <u>15A-</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital Andrews</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> <span style="float: right;">b. COUNTY <u>Fairfax</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u> d. STREET ADDRESS <u>206 Cheryl Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
<b>3. NAME OF DECEASED</b> (Type or print) <u>John</u> <u>A</u> <u>Klonowski</u>				<b>4. DATE OF DEATH</b> <u>November</u> <u>7</u> <u>19</u> <u>58</u>													
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Cauc</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3 Mar 85</u>		<b>9. AGE</b> (In years last birthday) <u>73</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Restaurant Owner</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Minnesota</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>									
<b>13. FATHER'S NAME</b> <u>unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give date or dates of service)		<b>16. SOCIAL SECURITY NO</b> <u>471 10 5105</u>		<b>17. INFORMANT</b> <u>Son</u>		<b>Address</b> <u>206 Cheryl Dr Falls Church, Va</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus - Cardia Arrhythmia</u> <u>464X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Thrombophlebitis</u> DUE TO (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 Days</u>									
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)								<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____									
<b>21. I certify that I attended the deceased from</b> <u>14 October, 19 58</u> , <b>to</b> <u>7 November, 19 58</u> , <b>that I last saw the deceased alive on</b> <u>7 November, 19 58</u> , <b>and that death occurred at</b> <u>1:55 PM</u> , <b>from the causes and on the date stated above.</b> <b>ADDRESS</b> (Street, city or town, state) _____ <b>DATE SIGNED</b> _____ <b>ACTUAL SIGNATURE</b> <u>Reginald P McManus M.D.</u> <u>USAF Hospital Andrews, Andrews AFB 7 Nov 58</u> <b>PHYSICIAN'S NAME (Type)</b> <u>REGINALD P MCMANUS CAPT USAF (MC) Washington 25, D. C.</u>																	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>			<b>22b. DATE THEREOF</b> <u>Nov. 10, 1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>WINONA</u>			<b>22d. LOCATION</b> (City, town, or county) _____ (State) _____ <u>WINONA MINNESOTA</u>									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>RINALDI FUNERAL HOME</u>					<b>ADDRESS</b> <u>WASH., DC. 816 HST. NE.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE NOV 10 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Turner</u>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12875

## CERTIFICATE OF DEATH

Reg. Dist. No. 12843

1. PLACE OF DEATH a. COUNTY <i>Prince George</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Pr. Geo.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural (Lanell)</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Lanell</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print) <i>Bernie A. Lammers</i>		4. DATE OF DEATH <i>November 6 1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 17, 1874</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Elkridge, Md</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Harry Otten</i>		14. MOTHER'S MAIDEN NAME <i>Mary Simon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Margaret Manning Lanell Md</i>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>		
(b) <i>Arteriosclerosis</i>		
(c) <i>Old age</i>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1. Prothrombotic Rx 8/30/58</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
--	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Fell out home</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>10</i> <i>8/30/58</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Lanell P.G. Md</i> (County) (State)	

21. I certify that I attended the deceased from <i>8/30</i> 1958 to <i>11/6</i> 1958 that I last saw the deceased alive on <i>11/6</i> 1958, and that death occurred at <i>1250</i> P.M. from the causes and on the date stated above	
ACTUAL SIGNATURE <i>B. P. Warren</i> M.D.	DATE SIGNED <i>11/6/58</i>
PHYSICIAN'S NAME (Type) <i>B. P. WARREN</i>	

22a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/10/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Marys Cem.</i>	22d. LOCATION (City, town, or county) <i>Lanell Maryland</i> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>De Witt Canadian</i> ADDRESS <i>Lanell Md</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 13 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Keith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12876

## CERTIFICATE OF DEATH

Reg. Dist. No. 12844

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u>	
c. LENGTH OF STAY IN 1b <u>32 yrs.</u>		d. STREET ADDRESS <u>Route 2 - Box 152</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>IRENE</u> First <u>E.</u> Middle <u>FAVIER</u> Last		4. DATE OF DEATH <u>Nov. 18 1958</u> Month <u>Nov.</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 10 - 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WAITER MARR</u>		14. MOTHER'S MAIDEN NAME <u>Virginia MARR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Virginia K. Frye</u>		Address <u>Route 2 - Box 152 Clinton MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peace coronary occlusion</u> <u>42c</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>General arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Natural Cause</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 10 - 1958</u> to <u>March 18, 1958</u> , that I last saw the deceased alive on <u>March 17, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Paul C. Linforth M.D. 5480 Station Rd. H.D.S.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>PAUL C. LIN FORTH</u> <u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>11-21-58</u>	<u>Washington Natl.</u>	<u>Seatons MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Bros</u>		24a. REG'D. BY REGISTRAR <u>1661-60th Ave SE</u> DATE <u>Nov 20 58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

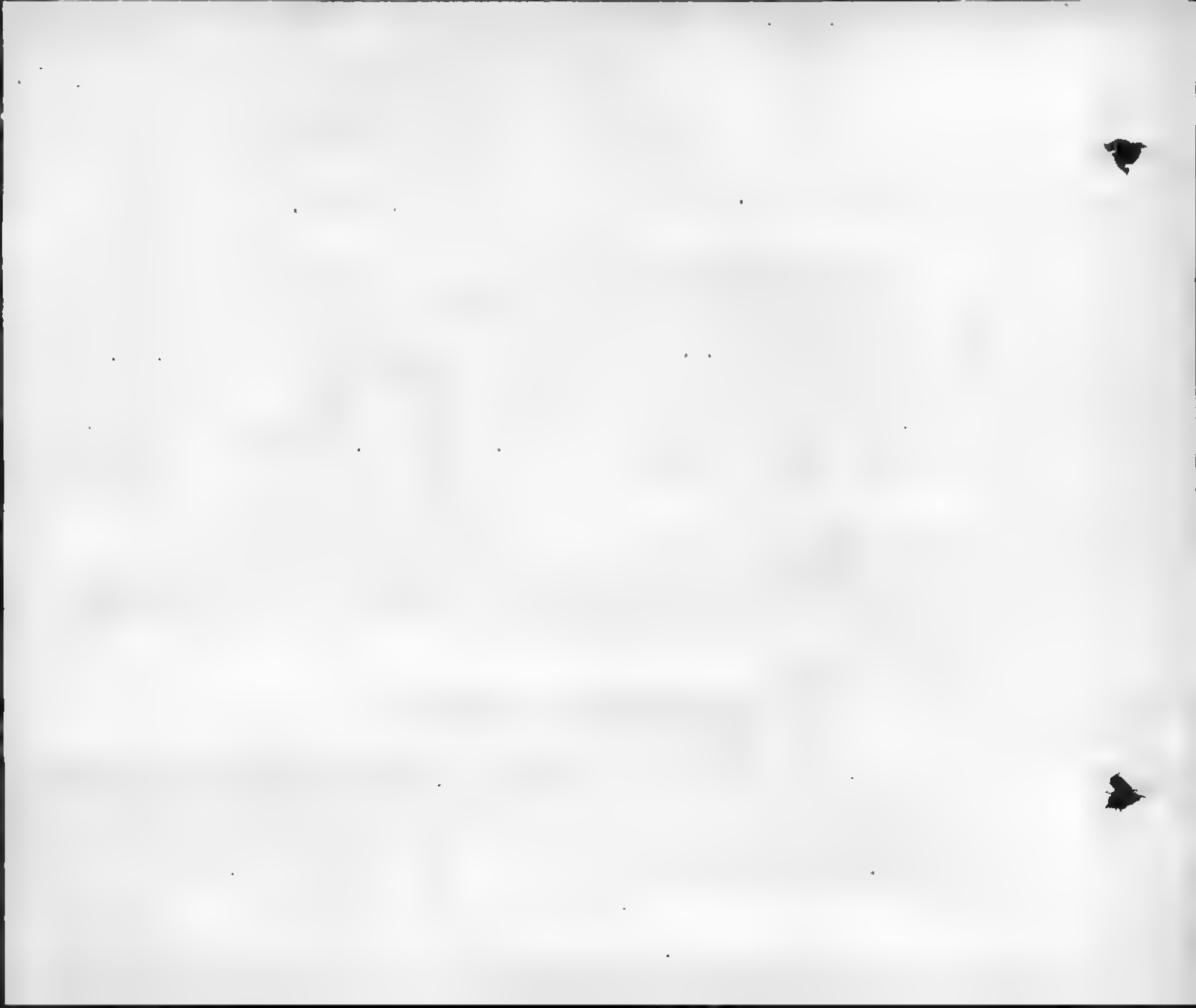
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12833  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN lb <b>11/2 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>W</b> Last <b>Laughlin</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1890</b>
9. AGE (In years last birthday) <b>68</b> yrs		IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. FIREMAN</b>	
11. BIRTHPLACE (State or foreign country) <b>WINONA, ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES LAUGHLIN</b>		14. MOTHER'S MAIDEN NAME <b>ANNA LAUGHLIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>(WIFE)</b> <b>MRS. CECELIA M. LAUGHLIN 5321-TAYLOR ROAD</b>		Address <b>RIVERDALE, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO <b>from botulism toxin: 16 the left arm. Art.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis the heart disease?</b> (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 16, 1958</b> to <b>November 16, 1958</b> , that I last saw the deceased alive on <b>November 16, 1958</b> , and that death occurred at <b>6:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Jeanne C Bateman</b>		DATE SIGNED <b>1816 "R" NW</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Jeanne C Bateman</b>		<b>Wash DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>NOV. 18, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>SUITLAND, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyson</b>		24a. REC'D BY REGISTRAR <b>DATE NOV 18 '58</b>	
ADDRESS <b>1300-N 34th NW WASH DC</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12877

## CERTIFICATE OF DEATH

Reg. Dist. No.

12846

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution—Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>			c. LENGTH OF STAY IN 1b <u>14</u> days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>939 R. I. Ave., N. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>John</u> Middle <u>H</u> Last <u>LEWIS</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>21</u> Year <u>1958</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/23/1900</u>		<b>9. AGE</b> (In years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS Hours <u>—</u> Min. <u>—</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Spotter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Needles Dry Cleaners</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John H. Lewis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Eliza Williams</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>578-18-3560</u>		<b>17. INFORMANT</b> <u>Decedent</u>		Address <u>—</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary hemorrhage</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis, far advanced</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u> <u>4 yrs., 6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <u>—</u> a. m. <u>19</u> p. m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>11/7</u> , 19 <u>58</u> , to <u>11/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/20</u> , 19 <u>58</u> , and that death occurred at <u>2:15 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Moe Weiss</u> M.D.				ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u>		DATE SIGNED <u>11/21/58</u>	
PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>				<u>Glenn Dale, Md.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>11/25/58</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Wash. D.C.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Phonon &amp; Johnson</u>				ADDRESS <u>4804 Thurgood Ave N.W.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>Nov 26 58</u>	<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Howard</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4, may be retained by the hospital or attending physician.  
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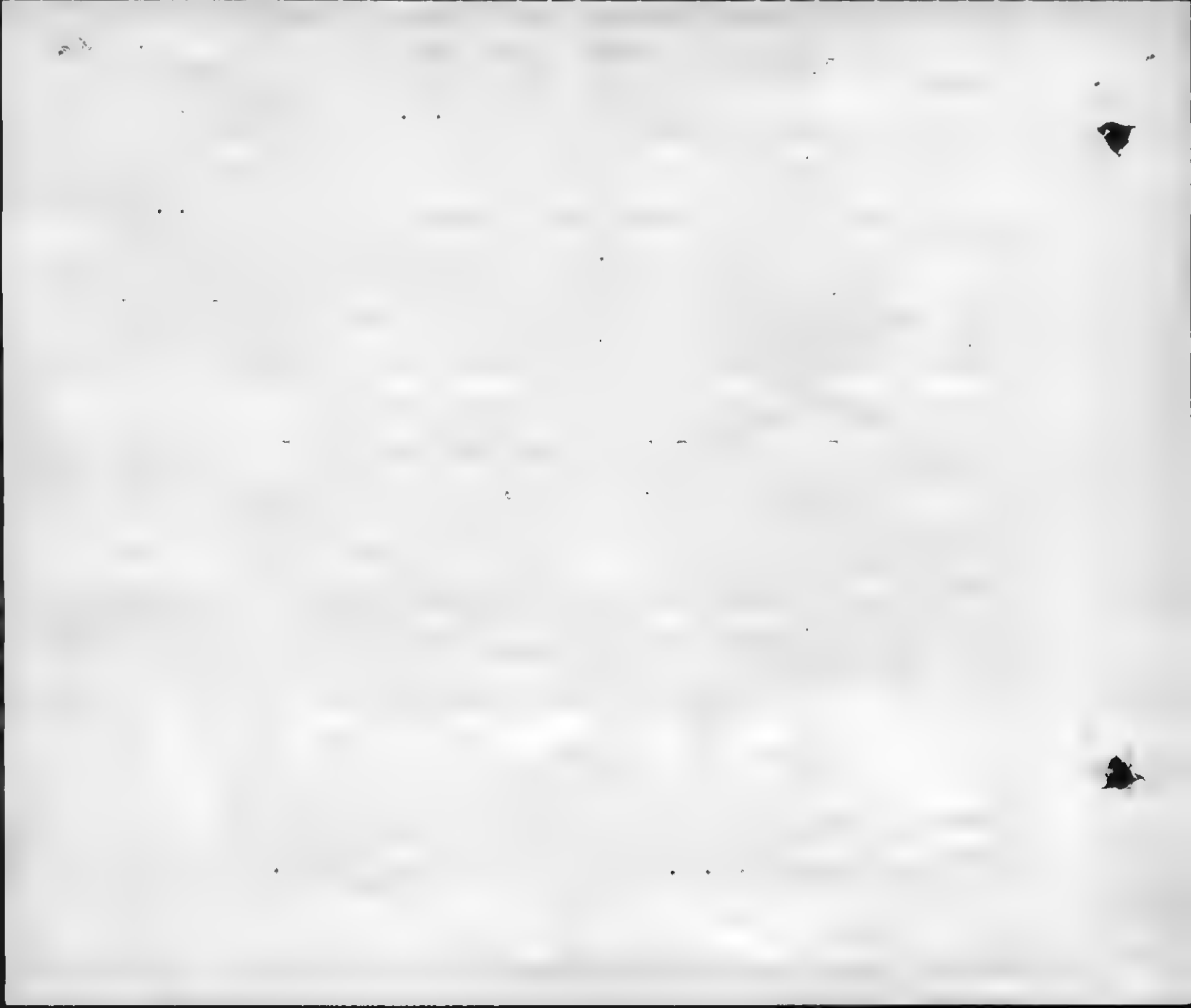
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12878

## CERTIFICATE OF DEATH

Reg. Dist. No. 12847

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE D. C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN lb 3 days		d. STREET ADDRESS 1234 Pleasant Street, S.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle S. Last Livesay		4. DATE OF DEATH Month 11 Day 22 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/20/01
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Orderly		10b. KIND OF BUSINESS OR INDUSTRY Baltimore City Hospital	11. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Joseph Livesay		14. MOTHER'S MAIDEN NAME Hedda Ann Tench	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 224-05-0823	17. INFORMANT Decedent
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, right lung, etiology undetermined DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis			INTERVAL BETWEEN ONSET AND DEATH 6 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/19, 19 58, to 11/22, 19 58, that I last saw the deceased alive on 11/22, 19 58, and that death occurred at 1:15 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Moe Weiss M.D. Glenn Dale Hospital 11/22/58 PHYSICIAN'S NAME (Type) Moe Weiss, M. D. Glenn Dale, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 11-25-58	22c. NAME OF CEMETERY OR CREMATORY Congressional	22d. LOCATION (City, town, or county) (State) Wash. D.C.
23. FUNERAL DIRECTOR'S SIGNATURE Michael J. Rinaldi 816 H St. N.E.		24a. REC'D BY REGISTRAR DATE NOV 26 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Film 236 Item 18 12-1-58 ams

12879

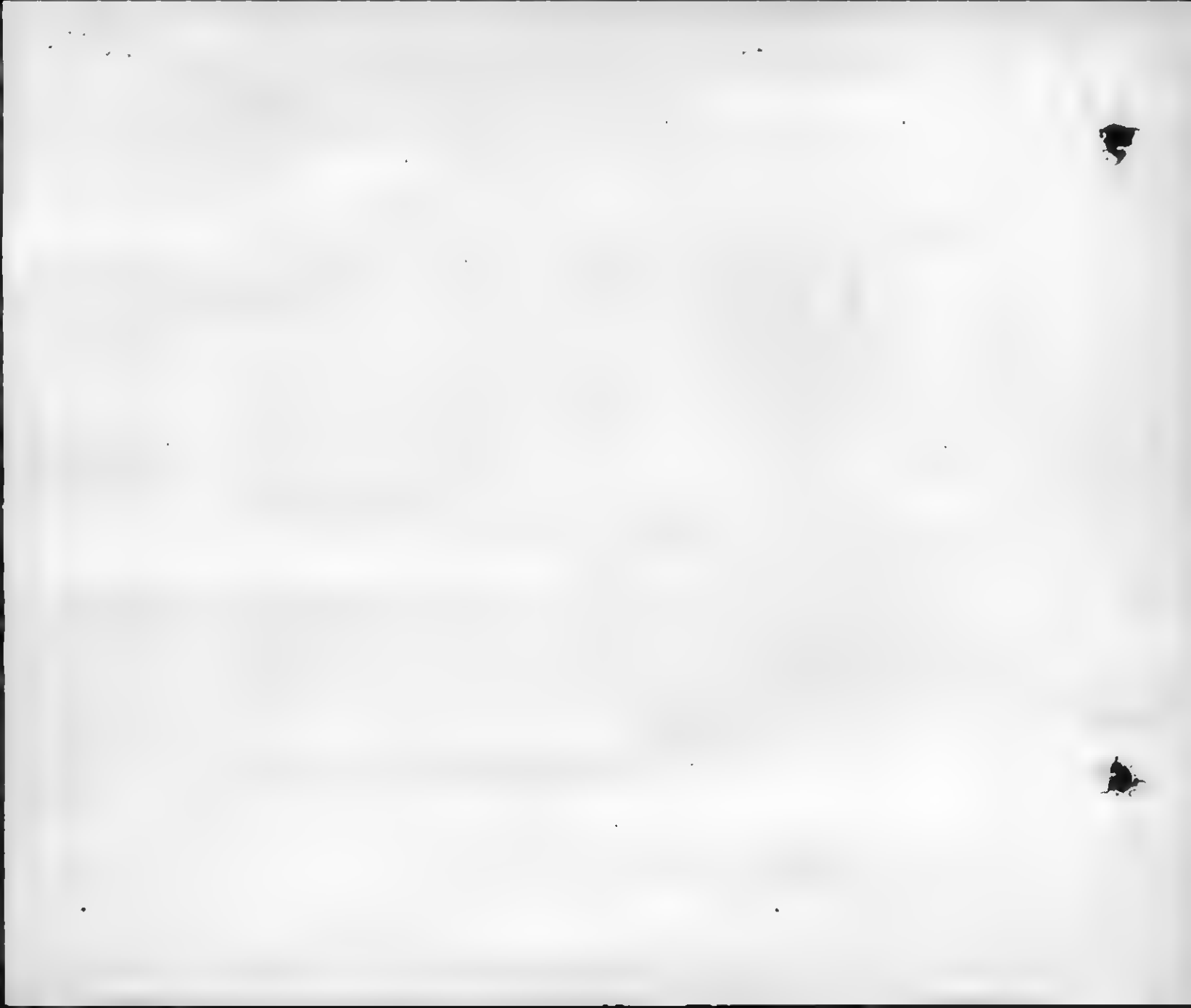
CERTIFICATE OF DEATH

Item 9, Film 6 236 12/1/58

Reg. Dist. No.

12848

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institut on Residence before admiss on) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AVONDALE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>AVONDALE</u>	
c. LENGTH OF STAY IN 1b <u>3 YRS.</u>		d. STREET ADDRESS <u>12012 HAYDEN ROAD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>M.</u> Last <u>MAHANEY</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-11</u>
9. AGE (In years last birthday) <u>46</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>17</u> Hours <u>47</u> Min. <u>47</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JEREMIAH MAHANEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY SHEEHY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-09-2038</u>	
17. INFORMANT <u>Mrs Mary Mahaney</u>		Address <u>Avondale Ind. 2012 Hayden Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO <u>Probably Carcinoma Right Breast</u> (b) <u>(This was cured by radical mastectomy)</u> DUE TO <u></u> (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NOV.</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 8, 1958</u> , to <u>Nov. 19, 1958</u> , that I last saw the deceased alive on <u>Nov. 18, 1958</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. van Kinsbergen</u> M.D.		ADDRESS (Street, city or town, state) <u>29 GRANT CIR., NW, Wash 11, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>M. VAN KINSBERGEN</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cemetery</u>		22d. LOCATION (City town or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u>		ADDRESS <u>3821-14th St NW, Wash, D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 20 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. S. H. H. H.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12880

## CERTIFICATE OF DEATH

12849

Reg. Dist. No.

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Prince Georges</u> <b>MARYLAND</b>				<b>2 USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>-</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <u>Washington</u>			
c. LENGTH OF STAY IN 1b <u>1 yr., 2 mos., &amp; 17 days</u>				d. STREET ADDRESS <u>55 S. St., N. W.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Glenn Dale Hospital</u>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Alton</u> Middle <u>-</u> Last <u>Marable</u>				<b>4. DATE OF DEATH</b> Month <u>11</u> Day <u>23</u> Year <u>19 58</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5/16/1896</u>	
<b>9. AGE</b> (In years last birthday) <u>62</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>-</u> Days <u>-</u>		<b>11. IF UNDER 24 HRS</b> Hours <u>-</u> Min <u>-</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Wm. E. Cramer Co.</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>North Carolina</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Antwine Marable</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Siller Berg</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>				<b>16. SOCIAL SECURITY NO.</b> <u>226-12-6401</u>		<b>17. INFORMANT</b> <u>Decedent</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral, etiology undetermined</u> <u>DO &amp; X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Bronchopleural fistula, right lung</u> DUE TO and resection of superior (c) <u>Right upper lobectomy/segment of right lower lobe</u> <u>for tuberculosis, 11/1/58</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a. p.</u> <u>19</u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>9/6/57, 19--</u> , to <u>11/23</u> , 1958, that I last saw the deceased alive on <u>11/23</u> , 1958, and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenn Dale Hospital</u> DATE SIGNED <u>11/23/58</u> ACTUAL SIGNATURE <u>Moe Weiss</u> M.D. <u>Glenn Dale Hospital</u> PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u> <u>Glenn Dale, Md.</u>							
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)		<b>22b. DATE</b> HEREOF <u>11 24 / 58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Muirkirk, Maryland</u>		<b>22d. LOCATION</b> (City, town, or county) (State)	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John T. Rhines &amp; Co.</u>				<b>ADDRESS</b> <u>3015-12th St. N.E.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>NOV 26 '58</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur E. Kline</u>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12881

CERTIFICATE OF DEATH

Reg. Dist. No.

12850

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>DIST. OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENN DALE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENN DALE HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>EDWARD L. McCOLLUM</b>		4. DATE OF DEATH Month Day Year <b>NOV. 1 1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/12/09</b>
9. AGE (In years last birthday) <b>49</b> yn.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MACHINE OPERATOR SUPPLY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N. CAROLINA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WILL McCOLLUM</b>		14. MOTHER'S MAIDEN NAME <b>LUCY BOYDS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO <b>239-14-4081</b>	
17. INFORMANT <b>DECEASED</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RT. LUNG BRONCHOGENIC CARCINOMA</b> DUE TO <b>METASTASIS TO RT. PLEURA.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>202X</b> (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>3 MONTHS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULM. TUBERCULOSIS ACTIVE, EXTENT UNDET.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/23</b> , 19 <b>58</b> , to <b>11/1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/1</b> , 19 <b>58</b> , and that death occurred at <b>9:00</b> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>MOE WEISS</b>		M.D. <b>GLENN DALE HOSP.</b> DATE SIGNED <b>11/5/58</b>	
PHYSICIAN'S NAME (Type) <b>MOE WEISS M.D.</b>		<b>GLENN DALE, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b. DATE THEREOF <b>11/2/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>WINSTON SALEM, N. C.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. ...</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE NOV 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Reg. Dist. No. 12851

1. PLACE OF DEATH a. COUNTY <b>Prince George</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission on) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Landover Hills</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				d. STREET ADDRESS <b>4206 72nd Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Raymond</b>		Middle <b>J</b>		Last <b>Mealy</b>		4. DATE OF DEATH Month <b>November</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18 1901</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months <b>57</b>		IF UNDER 24 HRS Days <b>57</b>		Hours <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk Genl Accounting Office U.S. Govt Wash. D.C.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Michael J. Mealy</b>				14. MOTHER'S MAIDEN NAME <b>Johanna Reidy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Katherine Mealy</b>		Address <b>---</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Carcinomatosis</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b). <b>Carcinoma of the body and tail of the pancreas</b> DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>Jan. 1944</b> to <b>Nov. 9, 1958</b> , that I last saw the deceased alive on <b>Nov. 9, 1958</b> , and that death occurred at <b>9:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4314 S. G. St. Hyattsville, Md.</b> DATE SIGNED <b>Mr. U</b> ACTUAL SIGNATURE <b>Till Bergman</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Till Bergman</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>11-12-1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem</b> 22d. LOCATION (City, town, or county) (State) <b>Bladensburg Rd. N.E. Washington, D.C.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers</b> ADDRESS <b>520 Cleveland Ave. N.W. Washington, D.C.</b> 24a. REC'D BY REGISTRAR <b>DATE NOV 12 58</b> 24b. REGISTRAR'S SIGNATURE <b>John L. Smith</b>							

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delayed for our use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be placed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 15

12852

12882

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oxon Run Cove</b> c. LENGTH OF STAY IN 1b <b>Govt. leased waters off Oxon Run Cove</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Govt. leased waters off Oxon Run Cove</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Res dence before adm ssion) a. STATE <b>Georgia</b> b. COUNTY <b>Ocilla</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocilla</b> d. STREET ADDRESS <b>Route #1</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Warren Levi MERRITT</b>				4. DATE OF DEATH Month Day Year <b>November 5 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-13-32</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13. FATHER'S NAME <b>Warren Henry MERRITT</b>				14. MOTHER'S MAIDEN NAME <b>Anna Lucille (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Korean</b>				16. SOCIAL SECURITY NO <b>259-44-2887</b>		17. INFORMANT <b>Official Navy Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO <b>424.8</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Drowning</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <b>While making routine training dive, failed to surface</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>9:15</b> <b>11 5 58</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Potomac River</b>				20f. (City or town) (County) (State) <b>Oxon Run Cove Pr. George Md.</b>			
21. I certify that I attended the deceased from <b>November 5, 1958</b> , to <b>November 5, 1958</b> , that I last saw the deceased alive on <b>November 5, 1958</b> , and that death occurred at <b>10:27 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Deep Sea Diving School 11-5-58</b>							
ACTUAL SIGNATURE <b>Paul G. LINAWEAVER, LT, MC, USN</b> M.D. <b>Deep Sea Diving School</b>							
PHYSICIAN'S NAME (Type) <b>Paul G. LINAWEAVER, LT, MC, USN</b> U.S. Naval Gun Factory, Washington, D. C.							
22a. REMOVAL OF BODY 22b. DATE THEREOF <b>Burial 11-5-58</b>				22c. NAME OF CEMETERY OR CREMATORY <b>--</b>			
22d. LOCATION (City, town, or county) (State) <b>Fitzgerald, N. C Georgia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Adams Funeral Home, 4748 Wisc. Ave., NW, Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>NOV 7 58</b>			
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

Prince George Co. Deputy Medical Examiner notified and remains released to Coroner, District of Columbia, who released remains to U. S. Naval Hospital, Bethesda, Md. for autopsy and disposition. Montgomery Co. Med. Exam. notified



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12835

## CERTIFICATE OF DEATH

Reg. Dist. No. 12853

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel</b>				c. LENGTH OF STAY IN 1b <b>13 X - 2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Laurel General Hospital</b>				d. STREET ADDRESS <b>Seagoville Rd Star Rt. Box 517</b>			
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Merson</b> Last <b>Merson</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1903</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nathan Vashington Merson</b>				14. MOTHER'S MAIDEN NAME <b>Laura Dustin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Hospital Records</b>		17. INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary infarct</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Cardiac failure and</b> DUE TO (c) <b>disseminated embolisms</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 months.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>11</b>	Day <b>10</b>	Year <b>1958</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 17, 1958</b> , to <b>November 7, 1958</b> , that I last saw the deceased alive on <b>November 7, 1958</b> , and that death occurred at <b>8:10 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Idolo Pierandrei</b> M.D.				PHYSICIAN'S NAME (Type) <b>Idolo Pierandrei, M.D. 305 Prince George Street, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<b>Burial</b>	<b>11/10/58</b>	<b>St. Paul Cem.</b>		<b>Laurel Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Witt Donaldson, Laurel Md</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12854

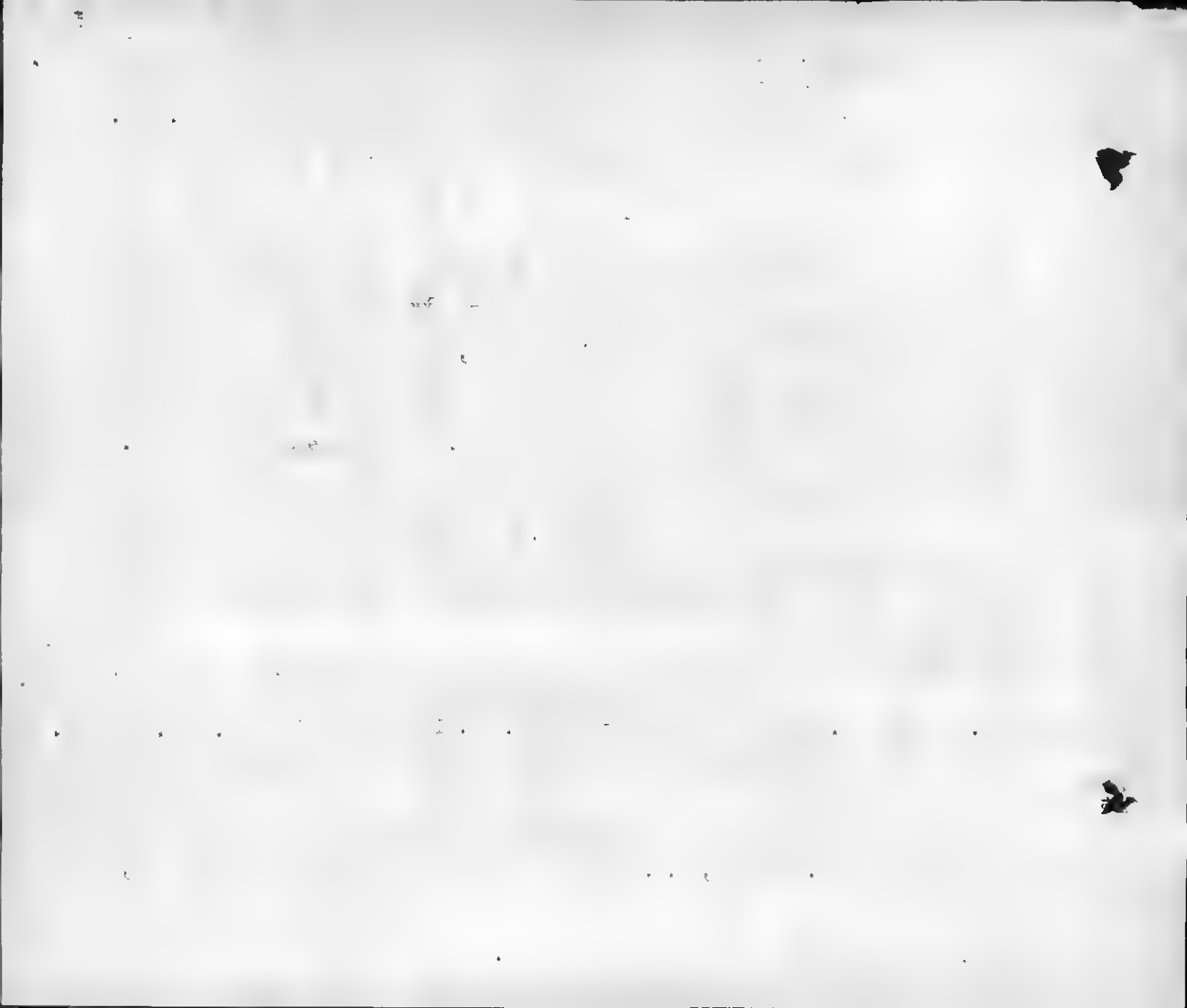
12836

FOR STATE  
HEALTH DEPT.

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1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>		e. STREET ADDRESS <b>11707 Ash Road</b>	
3. NAME OF DECEASED (Type or print) <b>Uldine Evelyn Meyer</b>		4. DATE OF DEATH <b>November 26 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-11-1925</b>
9. AGE (In years last birthday) <b>33 yrs</b>		10. IF UNDER 1 YEAR <b>Months Days Hours Min.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>S, Carolina</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Vincent Oliver</b>		14. MOTHER'S MAIDEN NAME <b>Cleo Morrell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Norman L. Meyer; same address as # 2.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fractured skull and legs</b> (a), stating the underlying cause last. DUE TO (c) <b>Automobile accident</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Operator of an automobile in collision with another automobile.</b>	
20c. TIME OF INJURY Month, Day, Year <b>8:50 p.m. Nov. 24, 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Rt. 1</b>		20f. (City or town) <b>Muirkirk Pr. Geo. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>November 26, 1958</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 29, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt Hope Cemetery</b>		22d. LOCATION (City, town, or county) <b>Florence South Carolina</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Maryland.</b>	
24a. REC'D BY REGISTRAR <b>DEC 2 58</b>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

12855

Reg. Dist. No.

12837

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Park</b>			
c. LENGTH OF STAY IN 1b <b>7 days</b>				d. STREET ADDRESS <b>6402 E. Street</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>Josephine</b> Middle <b>M</b> Last <b>Mills</b>				4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAR. 7<sup>TH</sup> 1898</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>60</b> Days <b>20</b> Hours <b>19</b> Min. <b>58</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>United States</b>				12. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MRS. GRACE V POORE</b> Address <b>6552 Ritchie Rd Wash, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>with metastases.</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 4</b> , 19 <b>52</b> , to <b>Nov. 20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Nov. 20</b> , 19 <b>58</b> , and that death occurred at <b>5:50 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William Brainin</b> M.D.				ADDRESS (Street, city or town, state) <b>6144 Central Ave</b> DATE SIGNED <b>11/20/58</b>			
PHYSICIAN'S NAME (Type) <b>WM BRAININ</b>				Capitol Hyge Inst			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11/23/58</b>		<b>Cedar Hill</b>		<b>Southland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b> ADDRESS <b>517 11<sup>th</sup> St SE</b>				24a. REC'D BY REGISTRAR <b>NOV 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.



FOR STATE  
HEALTH DEPT.

12883

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

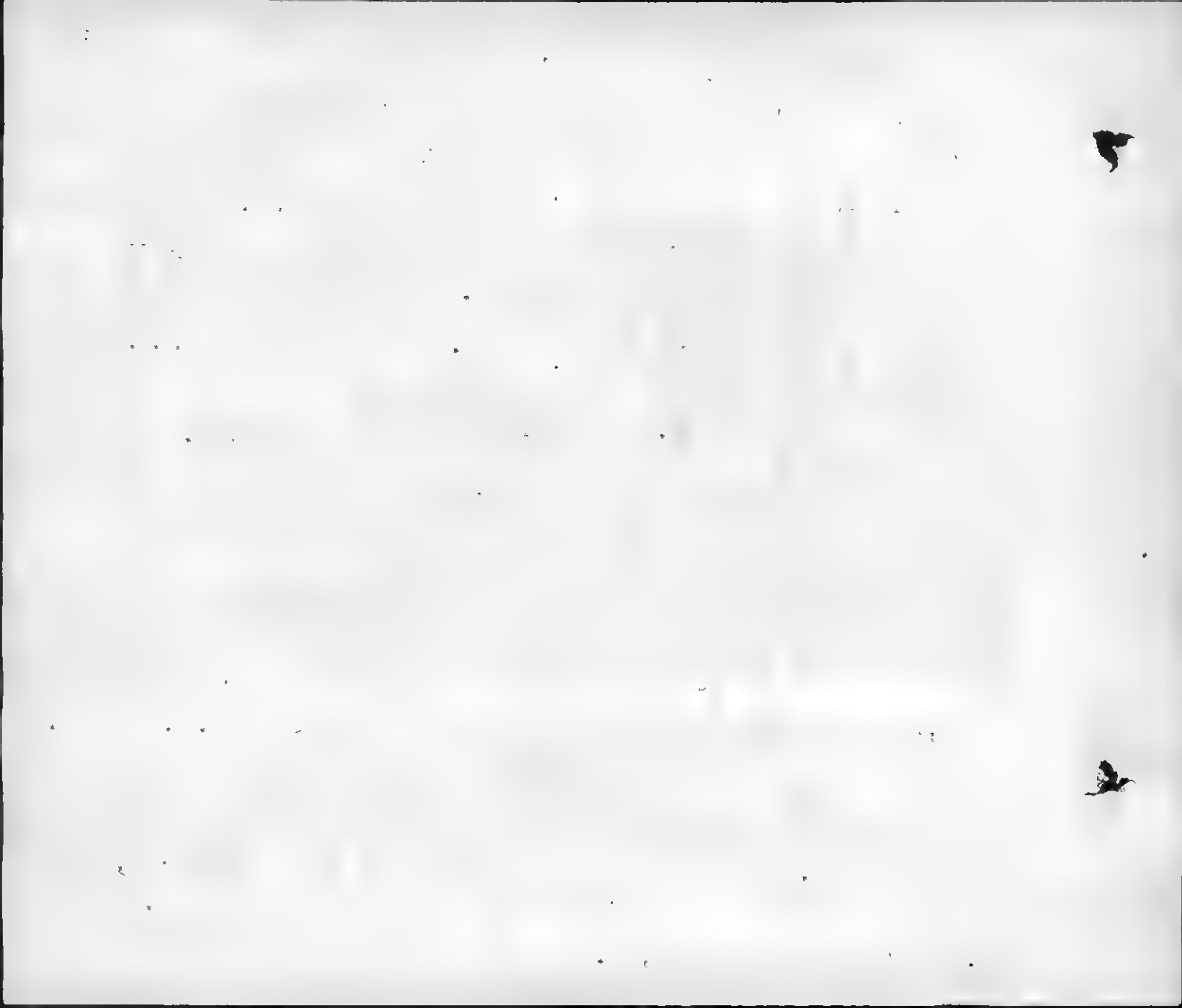
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12856

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accokeek</b>		c. LENGTH OF STAY IN IT <b>Transient</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Gardiner Road</b>		e. STREET ADDRESS <b>424 3rd Street N. W.</b>	
3. NAME OF DECEASED (Type or print) <b>Robert Bruce Minnix</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Aug. 1937</b>
9. AGE In years (birthdays) <b>21</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> M'n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Clifton Minnix</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Gillespie</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Mary Minnix (Mother)</b> Address <b>Salem, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Crushed skull and chest</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Occupant of an automobile that ran off road, struck fixed object</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>11:20</b> P.M. <b>11/10/58</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Gardiner Road</b>	20f. (City or town) (County) (State) <b>Accokeek P. G. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James I. Boyd</b>		DATE SIGNED <b>November 11, 1958</b>	
EXAMINER'S NAME (Type) <b>James I. Boyd</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/13/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>East Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salem Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 11 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kirsch</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

Film G236, items G.23.13 & 14 on 12/2/58

12838

CERTIFICATE OF DEATH

12857

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Seabrook</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>9434 DuBarry Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince Georges General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lehman</u> Middle <u>Norman</u> Last <u>Norman</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-80</u>
9. AGE (In years last birthday) <u>78 1/2</u> yrs		IF UNDER 1 YEAR: Months <u>11</u> Days <u>10</u> Hours <u>10</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Production</u>	
11. BIRTHPLACE (State or foreign country) <u>Flymouth, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Aquilla Norman</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cobb</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Marie B. Wife</u> Address <u>Same</u>	
17. INFORMANT <u>Marie B. Wife</u> Address <u>Same</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myo cardial infarctus</u> 440.0 DUE TO <u>Arterio sclerotic HTN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerotic HTN</u> DUE TO (c) <u>Arterio sclerotic HTN</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Id. age.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>11/22/58</u> Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/22/58</u> , to <u>11/27/58</u> , that I last saw the deceased alive on <u>November 26</u> , 19 <u>58</u> , and that death occurred at <u>9:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>4410 74 Ave.</u>		DATE SIGNED <u>11/27/58</u>	
PHYSICIAN'S NAME (Type) <u>F. E. HUSSEY, M.D.</u>		<u>Landon Hills, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/29/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>COOK FUNERAL HOME BALTO. MD.</u> ADDRESS <u>BALTO. MD.</u>		24a. REC'D BY REGISTRAR <u>NOV 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



12884

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Laurel)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Laurel)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF <u>Harry Lee Owens</u> (Type or print) First Middle Last		4. DATE OF DEATH <u>November 15, 1958</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 9, 1900</u> Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George W. Owens</u>		14. MOTHER'S MAIDEN NAME <u>Lissy Tucker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Wm Owens, Laurel Md.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Carcinoma Mouth + Neck</u> DUE TO (c) <u>3 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>47ix</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/1</u> , 19 <u>54</u> to <u>11/15/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/15/58</u> , 19 <u>58</u> , and that death occurred at <u>5A</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>11/17/58</u>			
ACTUAL SIGNATURE <u>J. M. Warren M.D.</u>		PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Nov 17, 1958</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Ing Hill Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Connelley</u>		24a. REC'D BY REGISTRAR <u>NOV 21 '58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>C. S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12885

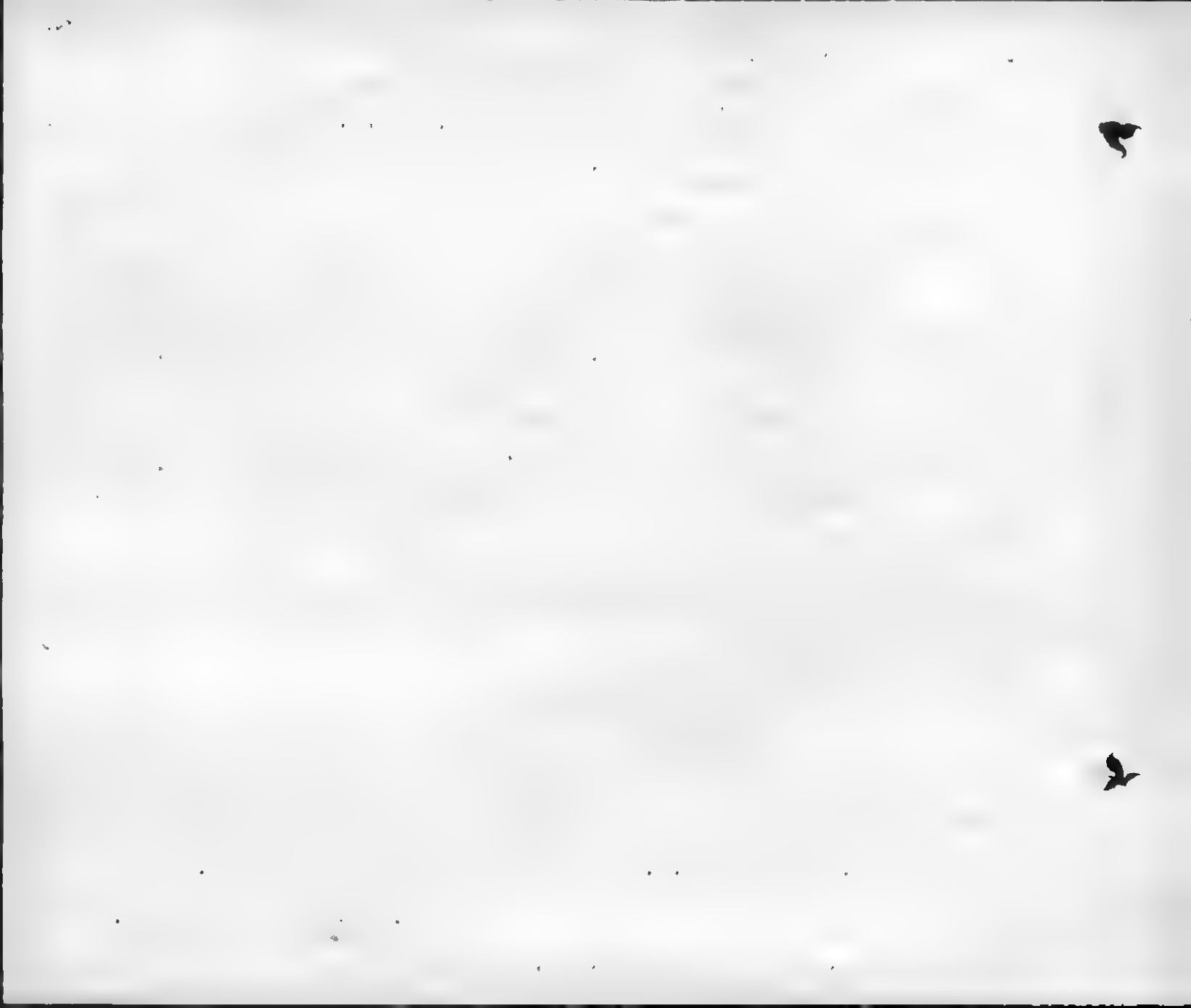
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges' MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE Md. & D.C. b. COUNTY Prince Georges' D.C.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b 20 yrs.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Church Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Henry First Middle Last		4. DATE OF DEATH Month Day Year Nov 28 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 13, 1896	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Engineer Naval Ord. Lab.		
11. BIRTHPLACE (State or foreign country) Japan		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Henry Deane Page		14. MOTHER'S MAIDEN NAME Sarah Gregg		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)		
17. INFORMANT Mrs. Dorothy Clark Page		Address Mitchellville		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
21. I certify that I attended the deceased from Nov 28, 1958, to Dec 25, 1958, that I last saw the deceased alive on Nov 28, 1958, and that death occurred at 10:45 M. from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. R. D. Sasse R, M.D. 10/24/58 PHYSICIAN'S NAME (Type) R. D. Sasse R, M.D. 10/24/58			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)	
12/1/58	12/1/58	Holt-Trinity Epis. Cem.	Collington, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Holt-Trinity Epis. Cem.		24a. REC'D BY REGISTRAR DATE DEC 3 '58		
ADDRESS		24b. REGISTRAR'S SIGNATURE William S. Howard		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12839 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

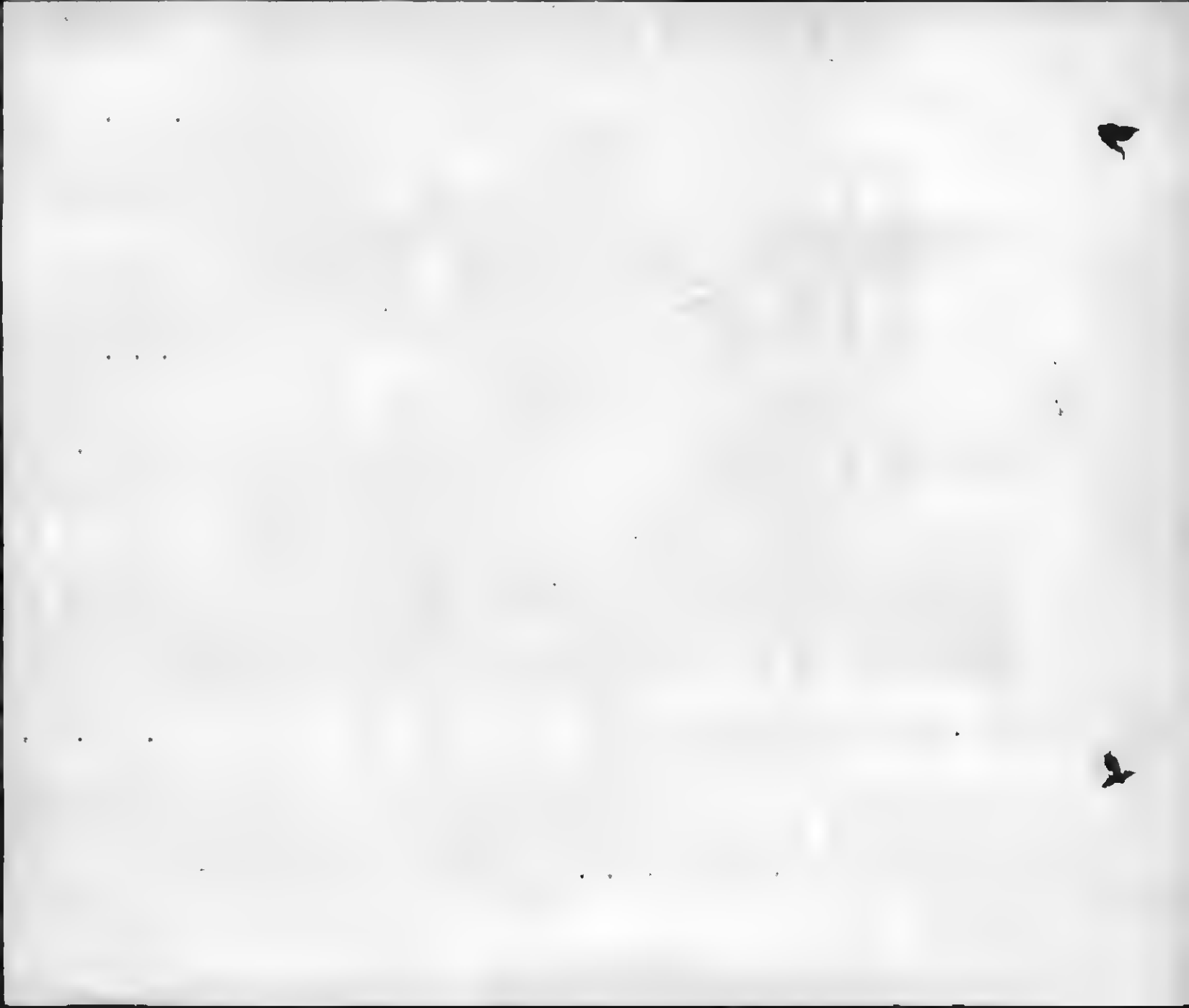
**12860**

**1**  
**FOR STATE**  
**HEALTH DEPT.**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>23 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Leland Memorial Hospiatl</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
f. STREET ADDRESS <u>3714 Jefferson Street</u>		<input type="checkbox"/> IS REF'DEN T ON A FAPM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jennie Vance Patton</u>		4. DATE OF DEATH Month <u>November</u> Day <u>26</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 1, '75</u> 83 yrs.
9. AGE (In years last birthday) <u>83 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Vance</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Stoner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>  </u>	
17. INFORMANT <u>Ruth Bradford; same address as # 2.</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of vomitus</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure due to shock</u> DUE TO (c) <u>Fracture of neck of femur</u>		<u>sudden</u>          <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Fall in home</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-25-58</u> Hour <u>11:30</u> a.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Hyattsville</u> (County) <u>Pr. Geo.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John T. Maloney</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John T. Maloney, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 29, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Beallsville Cemetery</u>		22d. LOCATION (City, town, or county) <u>Beallsville</u> (State) <u>Pennsylvania</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 2 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>		DATE SIGNED <u>11-26-58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMQ. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

12799

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

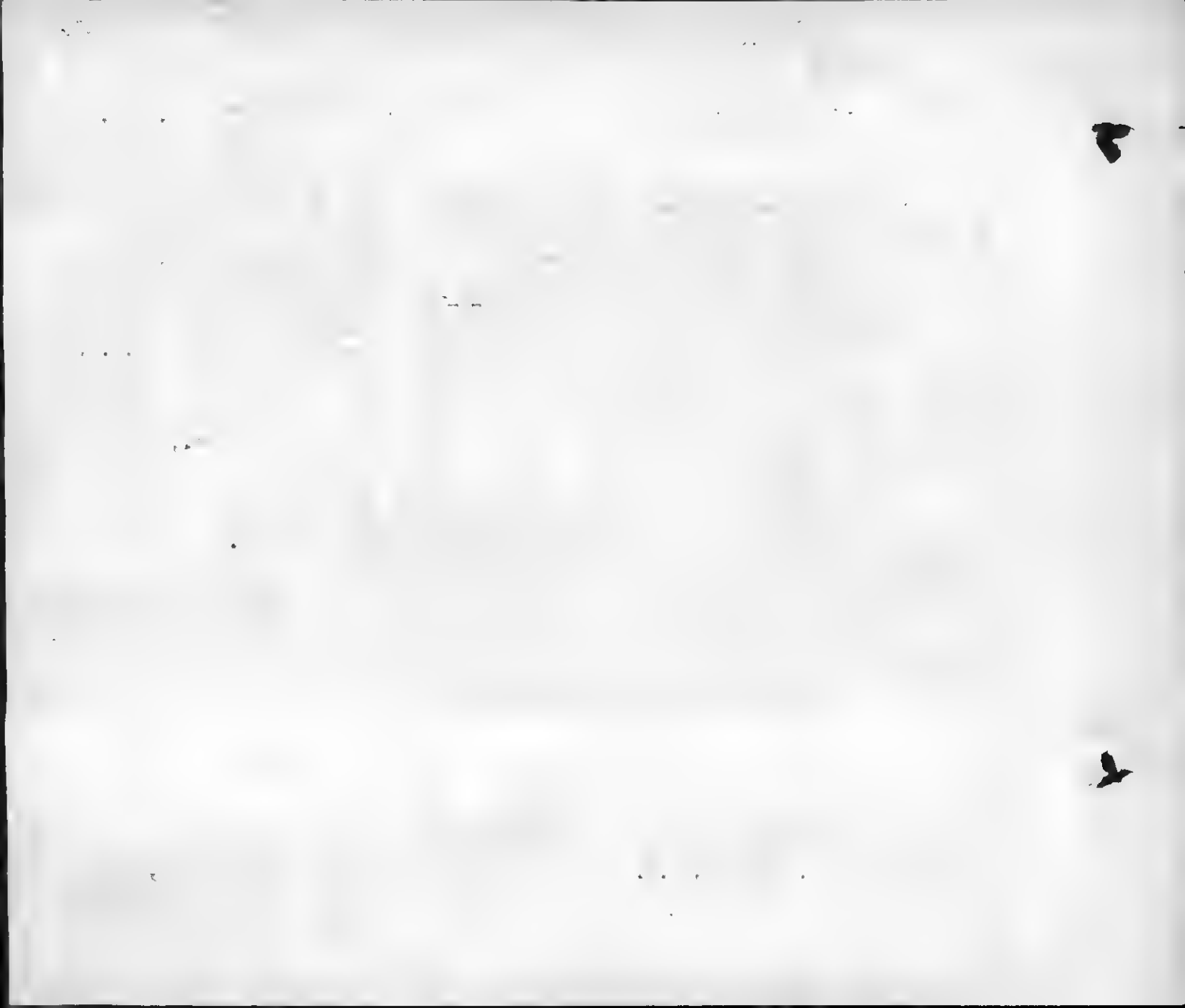
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12861

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> c. LENGTH OF STAY IN 1b <b>4 months</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colmar Manor</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hyattsville Convalescent Home</b>		e. STREET ADDRESS <b>3423 39th Place</b>	
3. NAME OF DECEASED (Type or print) <b>Amelia Pedone</b>		4. DATE OF DEATH <b>November 1, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-4-70</b>
9. AGE (In years last birthday) <b>80</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John (Pedone) OYERHOLZER</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO	
17. INFORMANT <b>John Pedone; 4311 Lawrence St., Colmar Manor</b>		Address <b>Maryland</b>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>			
14400 DUE TO (b) <b>Hypertensive cardiovascular disease.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>November 1, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>11-5-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lernard J. Ruck</b>		24a. REC'D BY REGISTRAR <b>5305 Harbor</b>	24b. REGISTRAR'S SIGNATURE <b>DATE NOV 5 '58</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12840 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr, Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>4620 R. Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Elizabeth</b> Last <b>Petrie</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 28, 1897</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles M. Shaw</b>		14. MOTHER'S MAIDEN NAME <b>Alberta Byer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>John Petrie; same address as # 2.</b>	
17. INFORMANT <b>John Petrie; same address as # 2.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary atherosclerosis</b> (c), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John T. Maloney</b>		DATE SIGNED <b>November 5, 1958</b>	
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 7, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Carroll S. Evans</b>			

THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health prior to burial, cremation, or removal, and is any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12841 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12863

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		2. USUAL RESIDENCE (Where deceased lived. If institut on residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P. Geo</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chapel Oaks</u> d. STREET ADDRESS <u>5707 Oates Street</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Junior Petty</u>		4. DATE OF DEATH <u>Nov- 23</u> 19 <u>58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-27-13</u>
9. AGE (In years last birthday) <u>45</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Binder</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Col.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Petty</u>		14. MOTHER'S MAIDEN NAME <u>Malinda Jackson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>Walter J. Petty - Washington, D.C.</u>	
17. INFORMANT <u>Kidney</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiogenic pulmonary edema</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Adhesive pericarditis</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH _____	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John D. Maloney</u> EXAMINER'S NAME (Type) <u>John D. Maloney, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>11-23-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/26/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>	22d. LOCATION (City, town, or county) <u>Laurel, Maryland</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Finney</u> ADDRESS <u>30 H Street, N.E.</u>		24a. REC'D BY REGISTRAR <u>NOV 25 58</u> DATE _____ 24b. REGISTRAR'S SIGNATURE _____	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: This certificate should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12842

CERTIFICATE OF DEATH

12864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN it 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 9014 Old Fort Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Plummer Last		4. DATE OF DEATH Month Nov. Day 22 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1882
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Catherine Butler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address N. E. Josephine Shorter 1227 Florida Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>ix</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 19, 1958, to Nov 22, 1958, that I last saw the deceased alive on Nov 22, 1958, and that death occurred at 9:10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Harry N. Carlton M.D.		ADDRESS (Street, city or town, state) 1816 R St, N.W. Wash DC DATE SIGNED 11/22/58	
PHYSICIAN'S NAME (Type) Dr. Harry N. Carlton			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-29-58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Rhinert Co. Washington D.C.		24a. REC'D BY REGISTRAR DATE NOV 28 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12800 Item 220, 2 File 5236 12-2-58 et  
CERTIFICATE OF DEATH

12865

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville		c. LENGTH OF STAY IN 1b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) W. Hyattsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5601-31st Ave.		d. STREET ADDRESS 5601-31st Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last Josie Portch		4. DATE OF DEATH Nov. 21 1958	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/1/1876
9. AGE (In years last birthday) 82		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Albemarle Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Coleman		14. MOTHER'S MAIDEN NAME Emma V. Thompkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) not		16. SOCIAL SECURITY NO 7104-Varnum Hills	
17. INFORMANT Helen M. Frith Daughter		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) cerebral thrombosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
DUE TO (b) arteriosclerosis			
DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 to 11/21/1958, that I last saw the deceased alive on 11/19/1958, and that death occurred at 3:30 PM, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) 7409 VARNUM ST.		DATE SIGNED 11/21/58	
ACTUAL SIGNATURE F. E. Mosser M.D.			
PHYSICIAN'S NAME (Type) F. E. Mosser		HANDOVER Hills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/24/58	22c. NAME OF CEMETERY OR CREMATORY Washington Nat. Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges County Md.
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Nalley's Funeral Home, Inc.		DATE NOV 26 '58	Charles S. Hanna



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12843  
CERTIFICATE OF DEATH

12866

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>adm. 4-2-55</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GREEN BURNIE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LAUREL SANITARIUM</u>				d. STREET ADDRESS <u>510 DELMAR AVE. S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>RENNIE</u> Last <u>RENNIE</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-2-1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. BORN</u>		13. FATHER'S NAME <u>WILLIAM TEEFER</u>		14. MOTHER'S MAIDEN NAME <u>Mrs. Ann</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>HOSPITAL RECORDS LAUREL SANITARIUM</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary congestion</u> <u>400.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>several hrs</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis with psychotic reaction</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>June</u> , 19 <u>56</u> to <u>Nov. 24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Nov. 24</u> , 19 <u>59</u> , and that death occurred at <u>8:15</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Erina P. Kraemer</u> M.D.				ADDRESS (Street, city or town, state) <u>LAUREL SANITARIUM</u> DATE SIGNED <u>11-24-59</u>			
PHYSICIAN'S NAME (Type) <u>ERINA P. KRAEMER</u>				<u>LAUREL MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/28/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FRIENDSHIP</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping &amp; Kirby</u> ADDRESS <u>Green Burnie, Md</u>				24a. REC'D BY REGISTRAR <u>NOV 25 1959</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12844 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12867

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated representative, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before adm'ssion) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges General Hospital</u>		e. STREET ADDRESS <u>511 - Commodity Hill Lane</u>	
3 NAME OF DECEASED (Type or print) <u>Grace</u>		4 DATE OF DEATH <u>Nov 22 1958</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>Sept 19 1921</u>	
9. AGE (In years, months, days) <u>37</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Camello Fisco</u>		14. MOTHER'S MAIDEN NAME <u>Louise Mangina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>442X</u>	
17. INFORMANT <u>Vincent Fisco</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> 442X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>stopping the underlying cause last.</u>		INTERVAL BET. TIME ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL OR CREMATION REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS</u>		24a. REC'D BY REGISTRAR <u>517 11th St. S.E., Wash, D.C.</u>	
24b. REGISTRAR'S SIGNATURE <u>Orlando L. Frank</u>		DATE <u>NOV 26 '58</u>	



FOR STATE  
HEALTH DEPT.

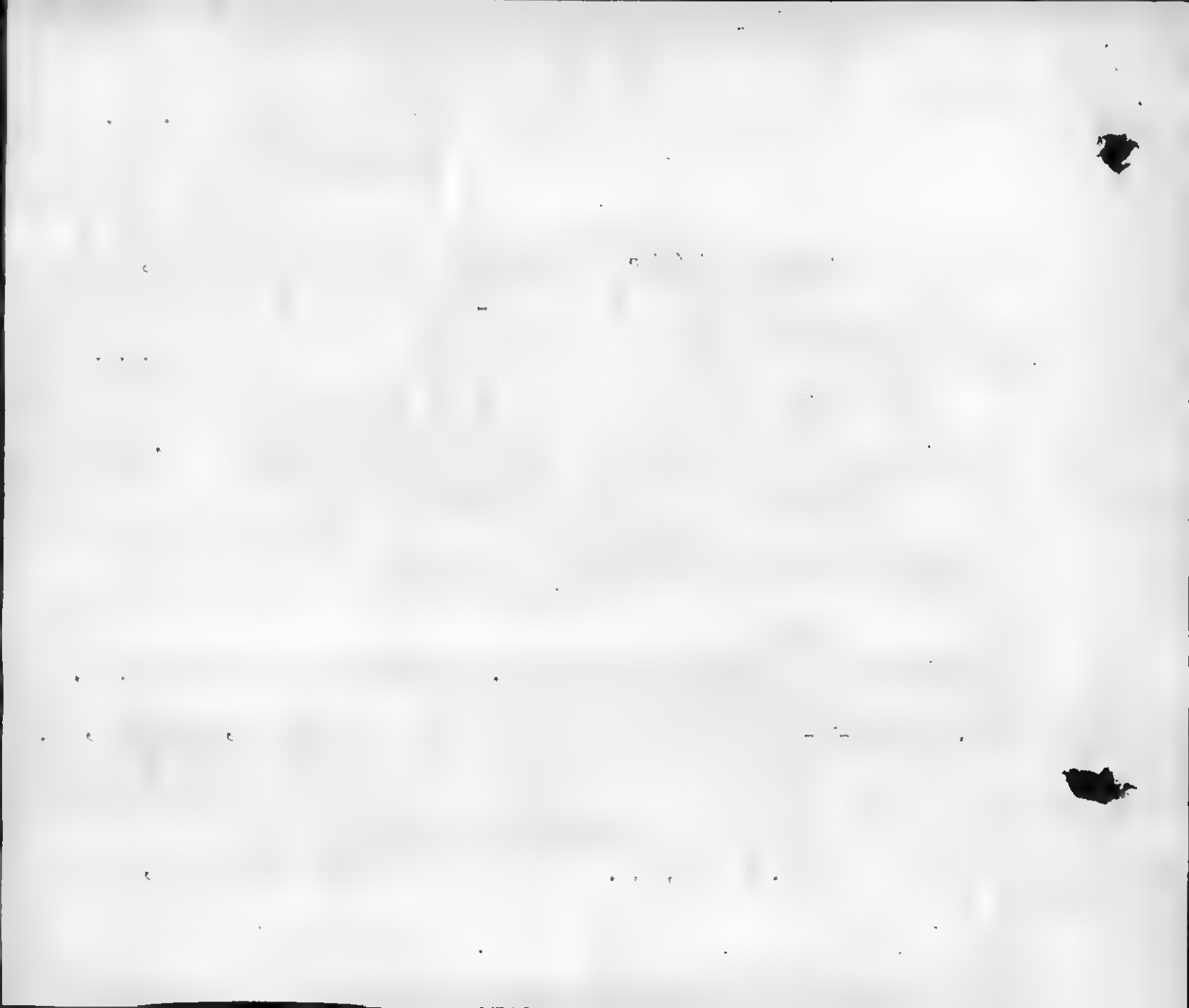
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12845 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12868

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>			c. LENGTH OF STAY IN 1b <b>3 weeks</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Prince Georges General Hospital</b>			e. STREET ADDRESS <b>2100 Charleston Place</b>		
3. NAME OF DECEASED (Type or print) <b>Elizabeth Philipina Robinson</b>			4. DATE OF DEATH <b>November 5, 1958</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-6-66</b>	9. AGE (In years last birthday) <b>92 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Jacob Weber</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Nicholas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>Hazel Sperry; same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial insufficiency</b>					
904.7 DUE TO (b) <b>Shock</b>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Fracture of right femur</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Fall in nursing home. 7417 Carroll Ave, Takoma Park, Md.</b>			
20c. TIME OF INJURY Month, Day, Year <b>4:00 p.m. 10-13-1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Nursing home</b>	
				20f. (City or town) (County) (State) <b>Takoma Park, Montgomery, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John T. Maloney</b>		EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>11/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GREEN LAWN CEMETERY</b>	
				22d. LOCATION (City, town, or county) (State) <b>COLUMBUS, OHIO</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, INC.</b>		ADDRESS <b>Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated representative, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12846**  
**CERTIFICATE OF DEATH**

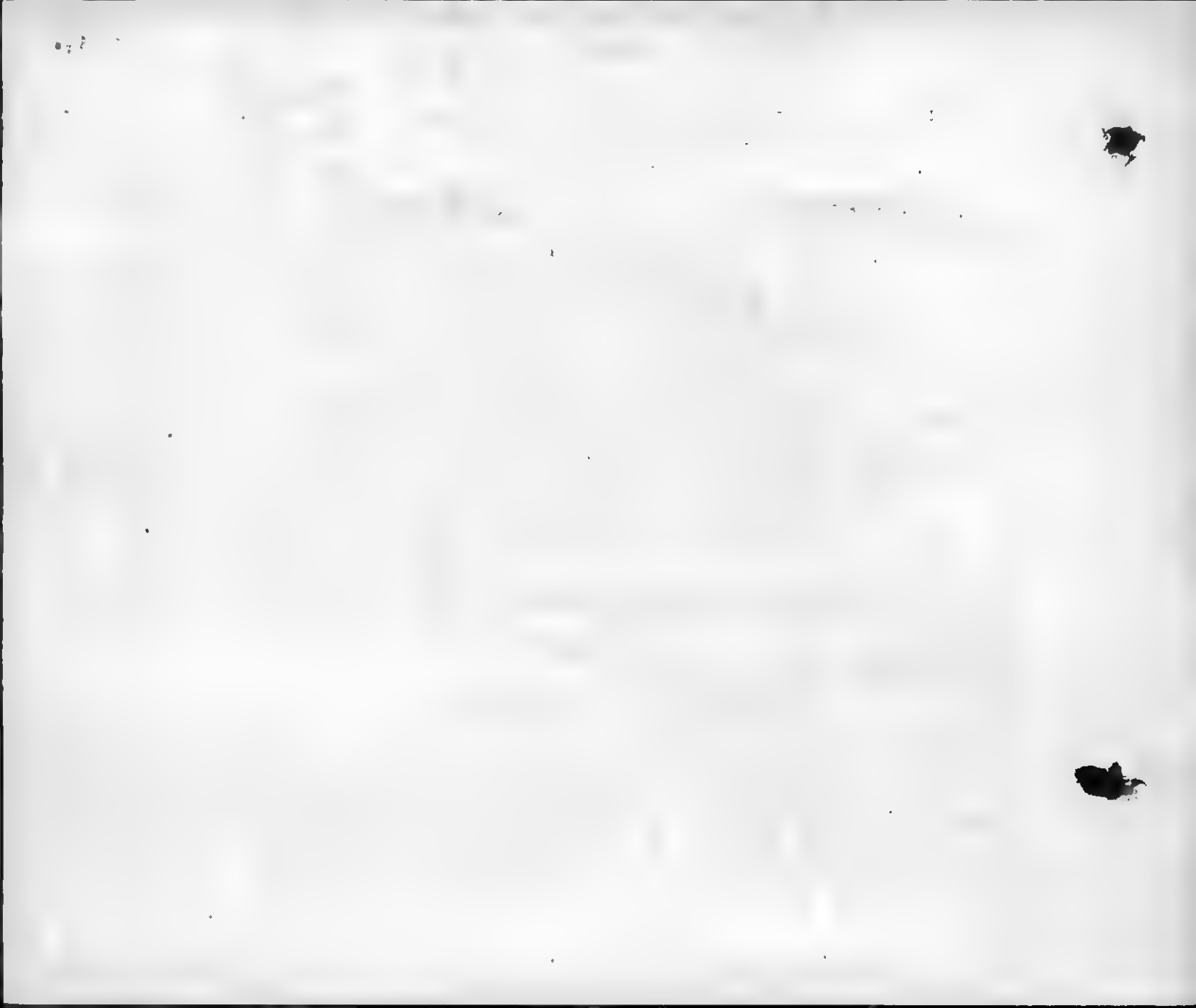
**12869**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>58 cheverly</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2711 Crest Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM Andrew</u>		First Middle Last <u>Rogers</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1896</u>	9. AGE (In years last birthday) <u>62</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>cloths</u>		11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William K Rogers</u>				14. MOTHER'S MAIDEN NAME <u>Mary M Nicol</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W 11</u>		17. INFORMANT Address <u>Josephine C Rogers Cheverly, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY Thrombosis</u>							<u>1 hr.</u>
DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							<u>9 yrs.</u>
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> 1953, to <u>Nov 4</u> 1958 that I last saw the deceased alive on <u>Nov 3</u> 1958, and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norman Donat Orman</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 PENNY ST</u>		DATE SIGNED <u>11/4/58</u>	
PHYSICIAN'S NAME (Type) <u>NORMAN DONAT ORMAN MTRAINIER MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 7, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>F. Gasch's Sons Hyattsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 10 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12847

## CERTIFICATE OF DEATH

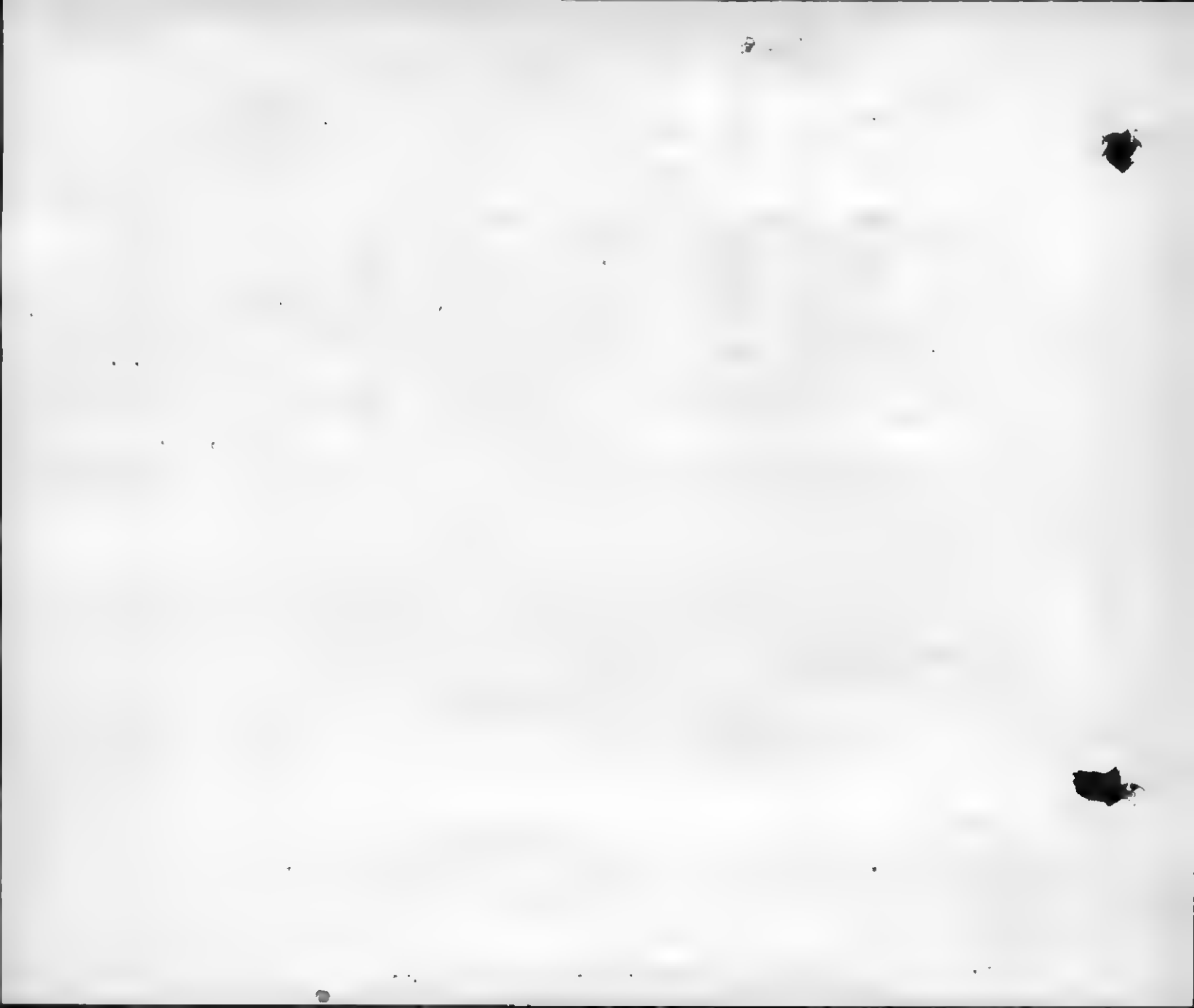
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admss on) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>				c. LENGTH OF STAY IN 1b <b>40 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince George General</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>J.</b> Last <b>Ross</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>2</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 27, 1874</b>	
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Plate Printer U S Government</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chicago, Illinois</b>			
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>Myrtle Dodson</b>			
17. INFORMANT <b>Myrtle Dodson</b>				Address <b>Hyattsville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b>							
4400 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <b>Failure</b>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>Arteriosclerotic Heart Disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11-1</b> 19 <b>58</b> , to <b>11-1</b> 19 <b>58</b> , that I last saw the deceased alive on <b>Nov 1</b> 19 <b>58</b> , and that death occurred at <b>6:35A</b> M. from the causes and on the date stated above							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>C. Deitz</b> M.D. <b>Hyattsville Md.</b> <b>11/1/58</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Aaron Deitz</b> <b>Hyattsville Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Nov 5, 1958</b>							
22c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>							
22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md.</b>							
24a. REC'D BY REGISTRAR <b>NOV 5 58</b> DATE							
24b. REGISTRAR'S SIGNATURE <b>Carroll S. Miller</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered to the funeral home for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

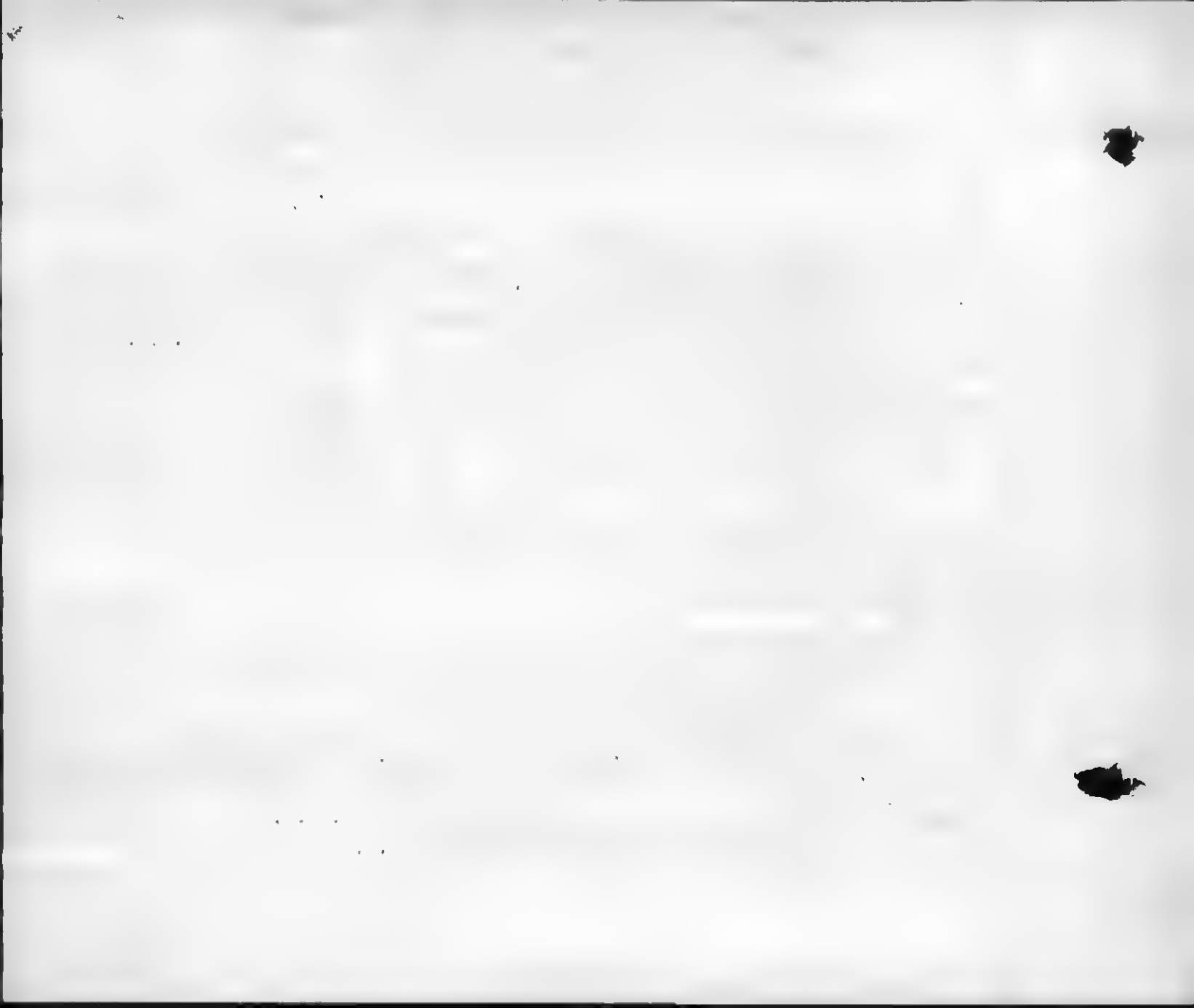
# 1 12848 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

14153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>20 Hr 5Min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Prince Georges General Hospital</b>		e. STREET ADDRESS <b>5609 Gallatin St.</b>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy Sapp</b>		4. DATE OF DEATH <b>Nov. 17 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>20</b> Months <b>5</b> Days <b>5</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marion Emory Sapp</b>		14. MOTHER'S MAIDEN NAME <b>Maxine Loraine Berry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mother</b> Address <b>Same</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>776x</b> <b>Immaturity</b> DUE TO (b) <b>Prematurity</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov. 16 1958</b> to <b>Nov. 17 1958</b> , that I last saw the deceased alive on <b>Nov. 17 1958</b> , and that death occurred at <b>11:30AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry E. Altman</b> M.D.		ADDRESS (Street, city or town, state) <b>1475 Euclid St. N.W.</b>	
PHYSICIAN'S NAME (Type) <b>Harry E. Altman</b>		DATE SIGNED <b>Washington, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>	22b. DATE THEREOF <b>12/5/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prince George's General Hospital, Cheverly, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harry W. Penn, Jr.</b> ADDRESS <b>Administrator.</b>		24a. REC'D BY REGISTRAR <b>DEC 10 '58</b>	24b. REGISTRAR'S SIGNATURE

2277262XVD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

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12801  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 2d & 22b, Film G-236, 11/26/58

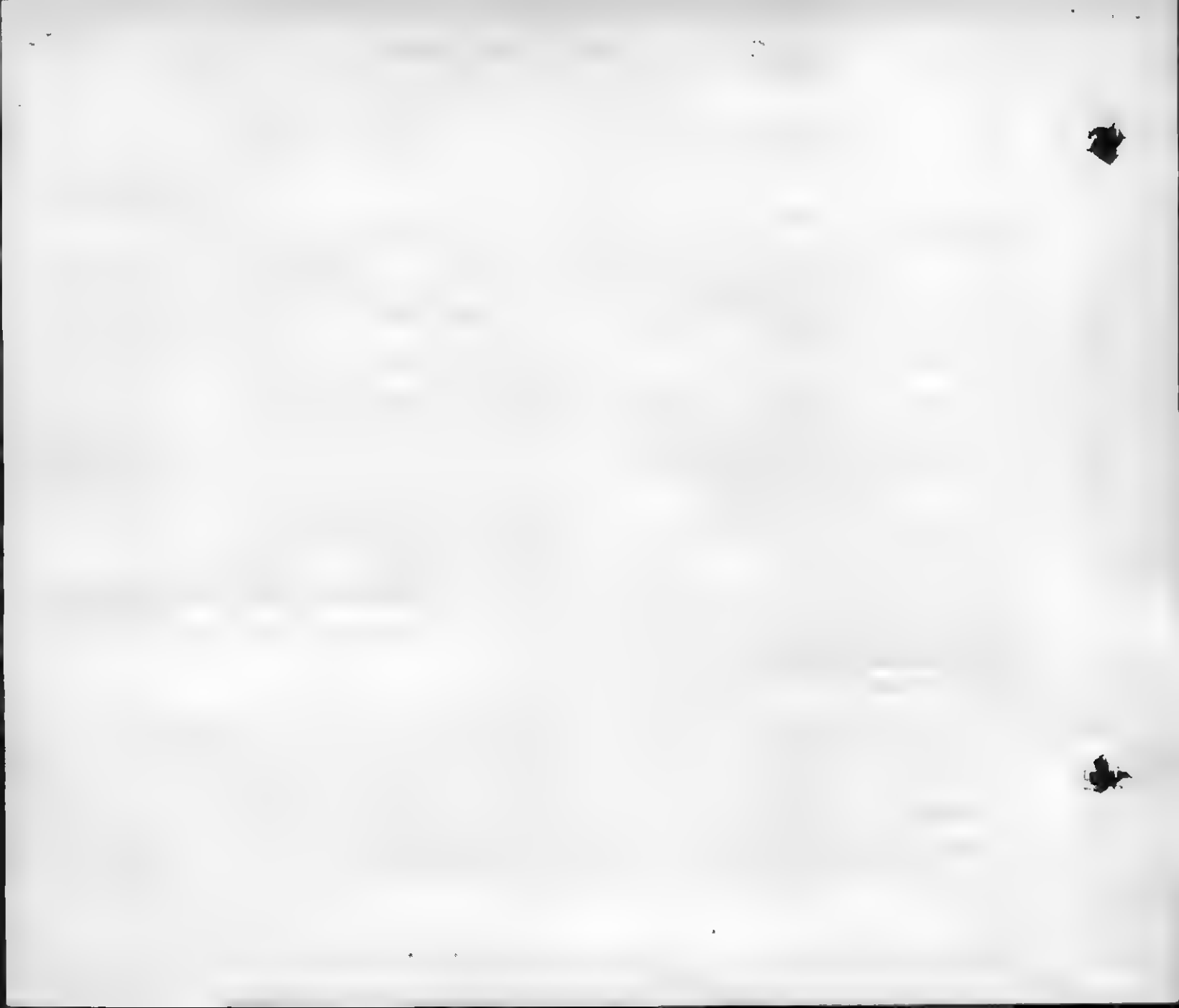
CERTIFICATE OF DEATH

12871

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Johnstown	
c. LENGTH OF STAY IN 1b 2 1/2 weeks		d. STREET ADDRESS 352 Arthur Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1500 Kanawha St Apt 203		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Maude Elsie Shaffer		4. DATE OF DEATH Nov 21, 1958	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 8, 1887
9. AGE (In years last birthday) 71 yrs		IF UNDER 1 YEAR: Months 13 Days 13 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11 BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME FRED HILL		14 MOTHER'S MAIDEN NAME SUSAN TRUAX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17 INFORMANT SUSAN SHAFER		Address 1500 KANAWHA ST APT 203	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4301 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Generalized Atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 11, 1958, to Nov 21, 1958, that I last saw the deceased alive on Nov 11, 1958, and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard L. Whelton M.D.		ADDRESS (Street, city or town, state) 1021 University Blvd E	
PHYSICIAN'S NAME (Type) Richard L. Whelton M.D.		DATE SIGNED Silver Spring Maryland	
22a. REMOVAL INFORMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/21/58	
22c. NAME OF CEMETERY OR CREMATORY Grand view Cemetery		22d. LOCATION (City, town, or county) (State) Johnstown, Pa	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Pumphrey Inc.		ADDRESS Silver Spring	
24a. REC'D BY REGISTRAR NOV 24 '58		24b. REGISTRAR'S SIGNATURE C. L. F. F. F.	

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12801  
Crown's Office will approve



12886

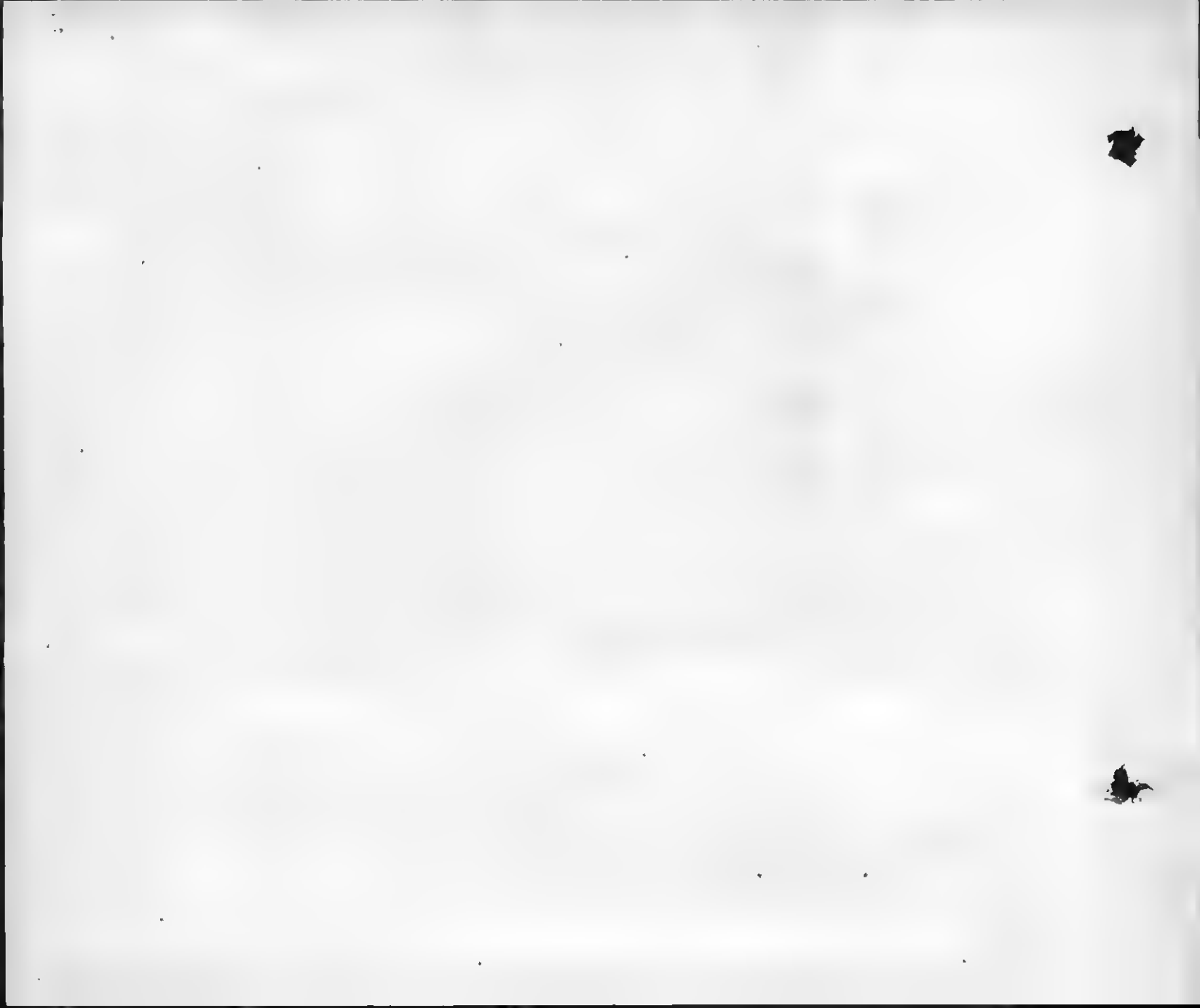
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince George's</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University Park, Md</b>		c. LENGTH OF STAY IN 1b <b>24 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4301 Claggett Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>L.</b> Last <b>Simmers</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> , Year <b>1958</b>	
5 SEX <b>male</b>	6 COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1876</b>
9. AGE (in years last birthday) <b>82</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farmer</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Jacob C Simmers</b>	
14. MOTHER'S MAIDEN NAME <b>Rebecca Layman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Oma R Sellers</b> Address <b>University Park, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Prostatic Obstruction (Prost.)</b> DUE TO (c) <b>Prostatic Hypertrophy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 month</b> <b>5 yrs 2</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4-11-1958 to 11-13-1958</b> <b>Bronchial Pneumonia &amp; Senility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-8</b> , 1958, to <b>11-13</b> , 1958, that I last saw the deceased alive on <b>11-13</b> , 1958, and that death occurred at <b>1:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3503 Perry St</b> DATE SIGNED <b>11-14-58</b>			
ACTUAL SIGNATURE <b>Waldo B. Moyers</b> M.D.		PHYSICIAN'S NAME (Type) <b>Dr. Waldo B. Moyers</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 16, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Harrisonburg, Va</b>		22d. LOCATION (City, town, or county) (State) <b>Harrisonburg Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville Maryland.</b>	
24a. REC'D BY REGISTRAR <b>NOV 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12849

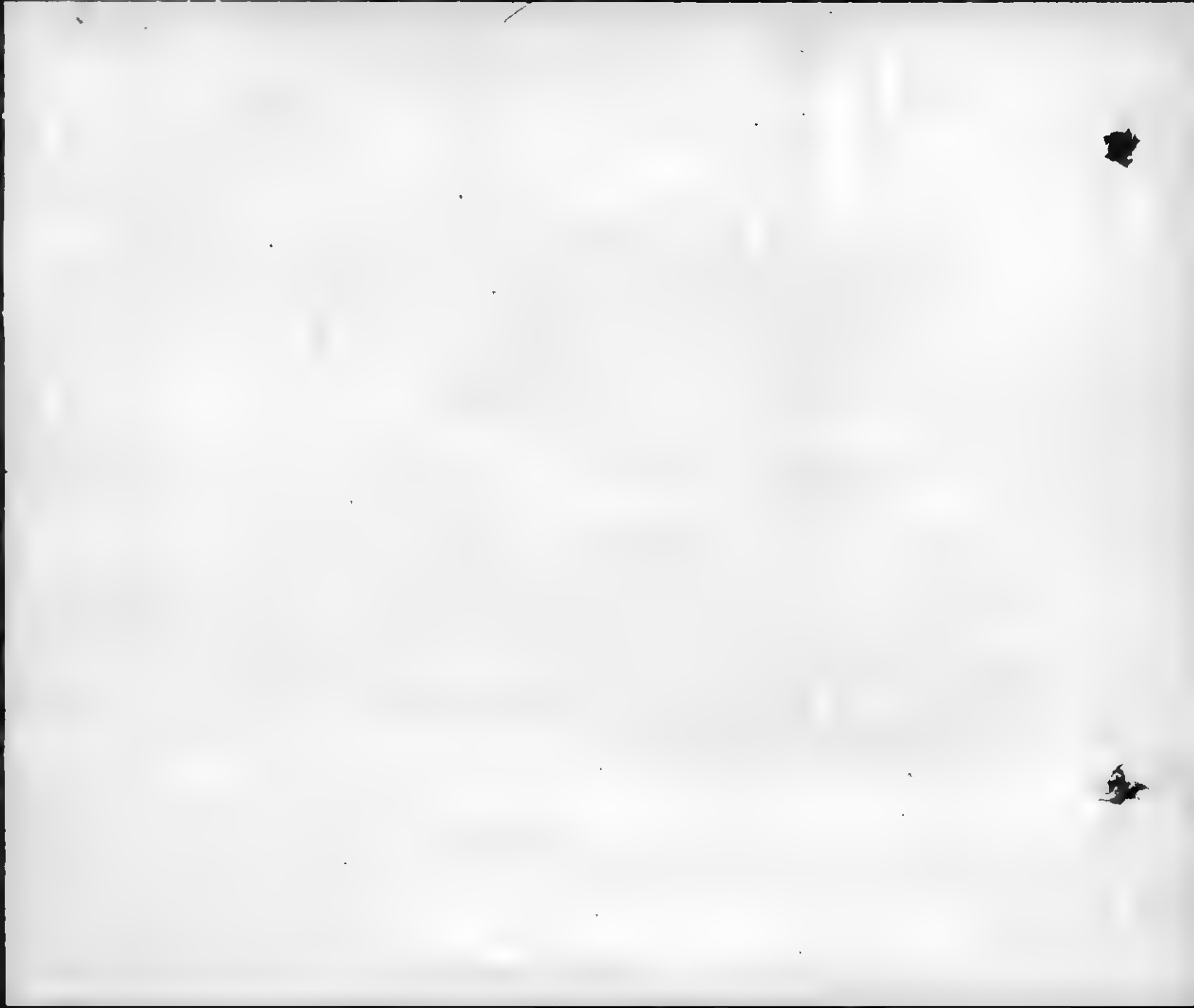
## CERTIFICATE OF DEATH

## 12873

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Prince George</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b> c. LENGTH OF STAY IN 1b <b>42 Days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Prince George General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Prince George</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>15 Hyattsville</b> d. STREET ADDRESS <b>1 5352 Quincy Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Jesse</b> Middle <b>Simpson</b> Last <b>Simpson</b>				<b>4. DATE OF DEATH</b> Nov. Month <b>30</b> Day <b>1958</b> Year					
<b>5. SEX</b> Male		<b>6. COLOR OR RACE</b> White		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> Aug. 24, 1881		<b>9. AGE</b> (In years, last birthday) <b>77</b> yrs IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____ IF UNDER 24 HRS: _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>PHARMACEUTIST</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>GEN. DRUG BUSINESS</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>PRINCE GEORGES CO. Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>WILLIAM SIMPSON</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ELIZABETH MOORE</b>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>578-466444</b>		<b>17. INFORMANT</b> <b>Mrs DOROTHY E. GALL, 642-A ST. N. E. Wash, D.C.</b> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>gangrene right Leg</b> DUE TO (b) <b>Embolus right Femoral Artery</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>6 weeks</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>8/19</b> , 19 <b>58</b> to <b>11/30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/30</b> , 19 <b>58</b> , and that death occurred at <b>2:20 A.M.</b> , from the causes and on the date stated above.									
<b>ACTUAL SIGNATURE</b> <b>Norman Donat Bureau</b>				<b>ADDRESS</b> (Street, city or town, state) <b>3503 Penny St. M.D.</b>				<b>DATE SIGNED</b> <b>11/30/58</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>NORMAN DONAT BUREAU</b>				<b>MT RAINIER MD</b>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>DEC 3, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>WASH'N NATIONAL CEM.</b>				<b>22d. LOCATION</b> (City, town, or county) (State) <b>SUITLAND P. GEOG Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John A. Hall</b>				<b>ADDRESS</b> <b>254 CARRILL ST NW D.C.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DEC 2 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>C. J. L. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12802

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville, Md.				c. LENGTH OF STAY IN 1b 9 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hyattsville Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park, Md			
d. STREET ADDRESS 9104 48th place				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last J. Frank Smith				4. DATE OF DEATH Month Day Year Nov 20, 1958 19			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 12, 1876	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry C Smith				14. MOTHER'S MAIDEN NAME Matilda Roberts			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO (If yes, give year or dates of service) 715 18 6471		17. INFORMANT Address Virginia Moles College Park, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 8-8-58, 19, to 11-20, 1958, that I last saw the deceased alive on 11-19, 1958, and that death occurred at 10:45 A.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>A. Reetz</u> M.D.				4314 - GALLATIN ST.			
PHYSICIAN'S NAME (Type) <u>AARON DETTZ, M.D.</u>				<u>HYATTSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 22, 1958		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Jasch's Sons Hyattsville, Md.				24a. REC'D BY REGISTRAR DATE NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

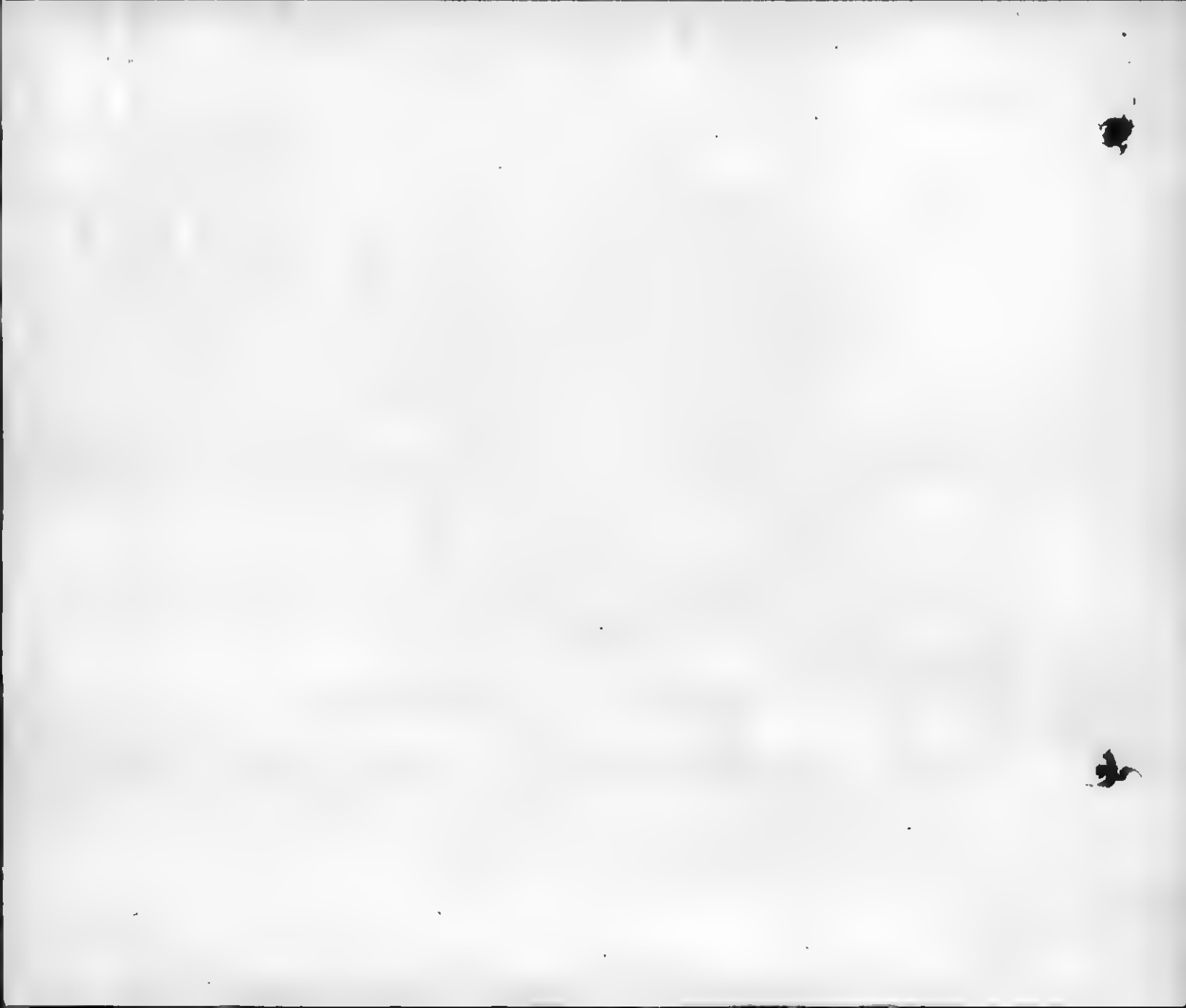


12887

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 23 DC</u>		c. LENGTH OF STAY IN IT <u>2 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4644 Davis Ave SE Washington 23 DC</u>		d. STREET ADDRESS <u>4644 Davis Ave SE DC</u>	
3. NAME OF DECEASED (Type or print) <u>Thomas Harrison Strahan Jr</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>8th</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 15 1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>odd jobs</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas H. Strahan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Gray</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Milton Strahan</u>		18. ADDRESS <u>4644 Davis Ave SE Washington 23 DC</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General Arteriosclerosis</u> (c) <u>Acute Cystitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>unknown</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none of note</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>58</u> , to <u>Nov 8</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 7</u> , 19 <u>58</u> , and that death occurred at <u>2:30</u> A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5440 Silver Mill Rd SE Washington DC</u> DATE SIGNED <u>  </u>			
ACTUAL SIGNATURE <u>Paul C Van Natta</u> M.D.		PHYSICIAN'S NAME (Type) <u>PAUL C VAN NATTA</u>	
22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town or county) (State) <u>Shutland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co Inc</u>		24a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>517 11th St SE</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
DATE <u>NOV 12 '58</u>			



12888

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dr. Dobsons Office		e. STREET ADDRESS 9 McKay Road	
3. NAME OF DECEASED (Type or print) Donald King Strong		4. DATE OF DEATH November 28 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1958
9. AGE (In years last birthday) 8 yrs		10. IF UNDER 1 YEAR 8 Months 17 Days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. KIND OF BUSINESS OR INDUSTRY Maryland D. C.	
13. FATHER'S NAME Charles Lewis Strong		14. MOTHER'S MAIDEN NAME Christine Kidd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Charles Lewis Strong, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia			
DUE TO (b) Due to smothering in bed clothing			
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Caught between the mattress and side of bed	
20c. TIME OF INJURY Month, Day, Year 12:30 AM 11/28/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Brandywine (County) P. G. (State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 2, 1958	
22c. NAME OF CEMETERY OR CREMATORY XXXXX		22d. LOCATION (City, town, or county) Arlington Va (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons Hyattsville Md.		24a. REC'D BY REGISTRAR DATE DEC 2 '58	
		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12850

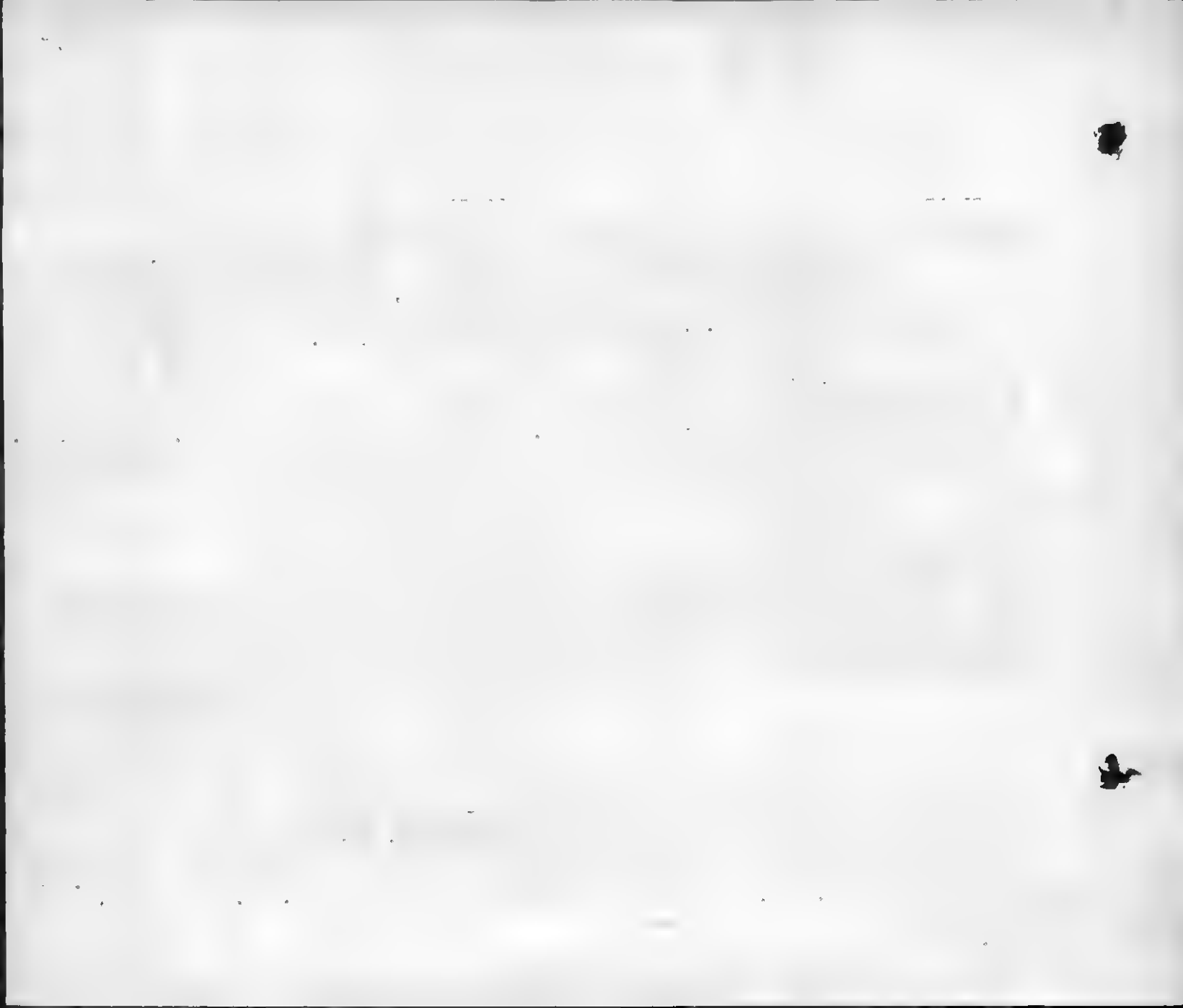
## CERTIFICATE OF DEATH

12877

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt</b>				c. LENGTH OF STAY IN 1b <b>6 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4--B--Ridge Road</b>				d. STREET ADDRESS <b>4--B--Ridge Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LAWRENCE</b> Middle <b>ELIJAH</b> Last <b>SULLIVAN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>26th</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 19th, 1906</b>	
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Naval Gun Factory</b>		11. BIRTHPLACE (State or foreign country) <b>Falls Church, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Edgar Elijah Sullivan</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Ann Beach</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>577-01-4194</b>		17. INFORMANT <b>Mrs. Rosella Sullivan, 4-B Ridge Rd. Greenbelt, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinoma</b> <b>16a.1</b> DUE TO <b>"Bronchogenic carcinoma"</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>14 months</b> (c)				INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>September 27, 1957</b> , to <b>November 26, 1958</b> , that I last saw the deceased alive on <b>November 25, 1958</b> , and that death occurred at <b>6:20A M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>30-C Ridge Road, Greenbelt, Md.</b> DATE SIGNED <b>11/26/58</b>							
ACTUAL SIGNATURE <b>Hans Wodak</b>				M.D. <b>30-C Ridge Road, Greenbelt, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Hans Wodak</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 29th, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cemetery</b>		22d. LOCATION (City, County, State) <b>Prince Georges Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Company, Riverdale, Md.</b>				24a. REC'D BY REGISTRAR <b>DEC 1 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





12803

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>PR. GEO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIVERDALE MD.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>		e. d. STREET ADDRESS <b>5506 - 57th AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>C.</b> Last <b>TANIS</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-21-'77</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Post Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Department</b>	
11. BIRTHPLACE (State or foreign country) <b>ISLE OF TEXELE, HOLLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.C.</b>	
13. FATHER'S NAME <b>Richard Tanis</b>		14. MOTHER'S MAIDEN NAME <b>Anna Mantie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>1056 PM TANIS-6614-7446, HYATTSVILLE MD.</b>	
17. INFORMANT <b>2.</b> Address <b>1056 PM TANIS-6614-7446, HYATTSVILLE MD.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
DUE TO <b>351X</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <b>ARTERIOSCLEROSIS, GENERALIZED</b>	
DUE TO		(c) <b>1 YEAR</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JAN 1</b> , 19 <b>58</b> , to <b>NOV 27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>NOV 27</b> , 19 <b>58</b> , and that death occurred at <b>4:50 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Samuel N. Sugar</b> M.D.		ADDRESS (Street, city or town, state) <b>4300 KAYWOOD DRIVE</b> DATE SIGNED <b>11-27-58</b>	
PHYSICIAN'S NAME (Type) <b>SAMUEL N. SUGAR</b>		<b>MT. RAINIER MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>12/1/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Rainier, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. J. J. J.</b> ADDRESS <b>475-H 24th St.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 1 '58</b>	24b. REGISTRAR'S SIGNATURE <b>(Inking &amp; Kana)</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12851 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

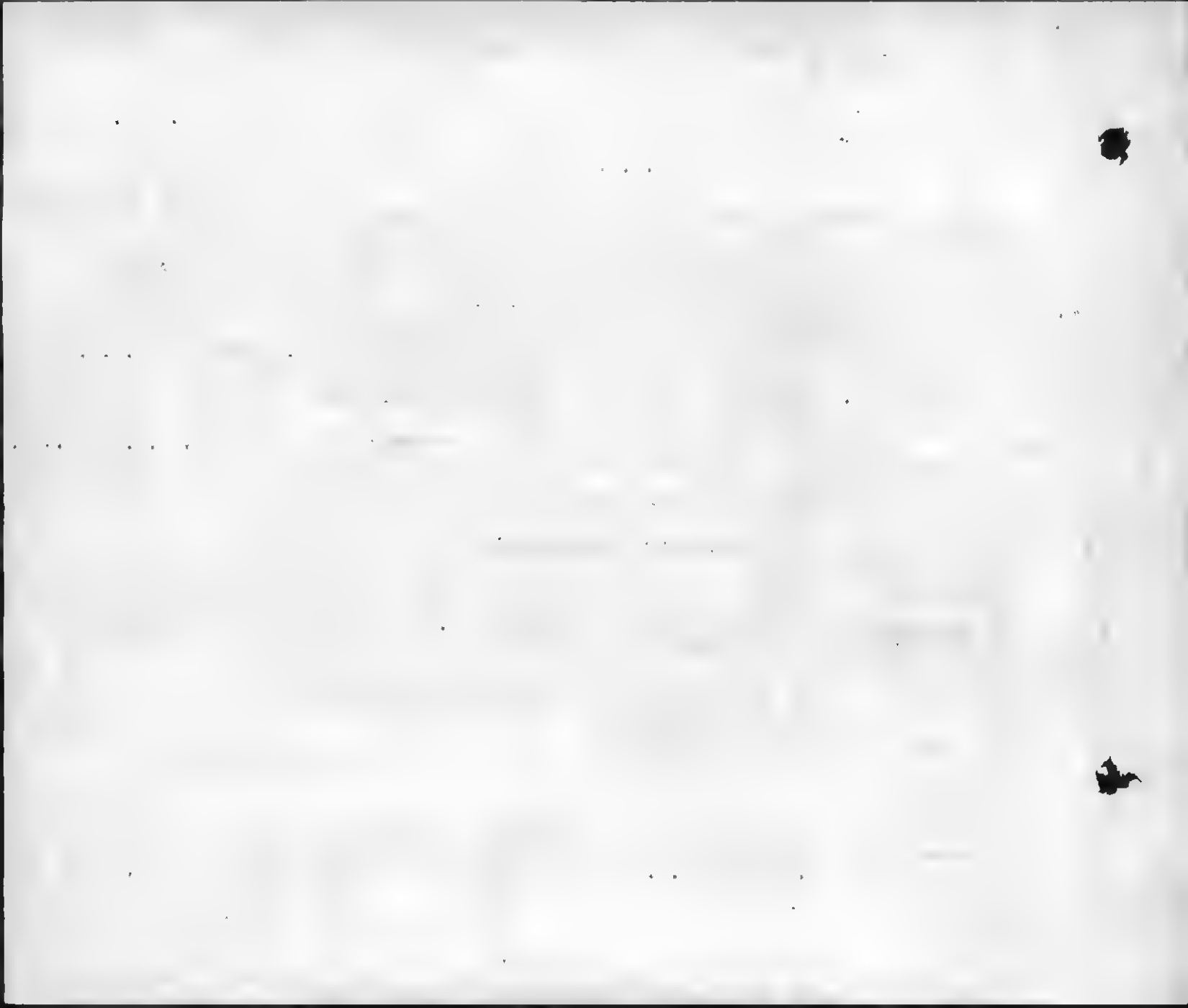
12879

**FOR STATE  
HEALTH DEPT.**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, wr to RURAL and give nearest town) <b>Riverdale</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, wr to RURAL and give nearest town) <b>Hyattsville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Leland Memorial Hospital</b>				d. STREET ADDRESS <b>5708 Ager Road</b>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Adell Taylor</b>				4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-19-19</b>	
9. AGE (In years last birthday) <b>39</b> yrs.		10. IF UNDER 1 YEAR Months <b>39</b> Days <b>39</b> Hours <b>39</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Aberta Province, Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>William D. Woodward</b>				14. MOTHER'S MAIDEN NAME <b>Amy Morehouse</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Hazel Woodward; 1314 Floral St. N.W. Wash., D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary tuberculosis</b> DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cirrhosis of the liver, Chronic pancreatitis.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John T. Maloney</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John T. Maloney M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>November 10, 1958</b>			
22a. BURIAL CREMATION REMOVAL (Spec fy) <b>Burial</b>		22b. DATE THEREOF <b>Nov 13, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville Maryland.</b>		24a. REC'D BY REGISTRAR <b>NOV 14 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. J. ...</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death.



12889

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

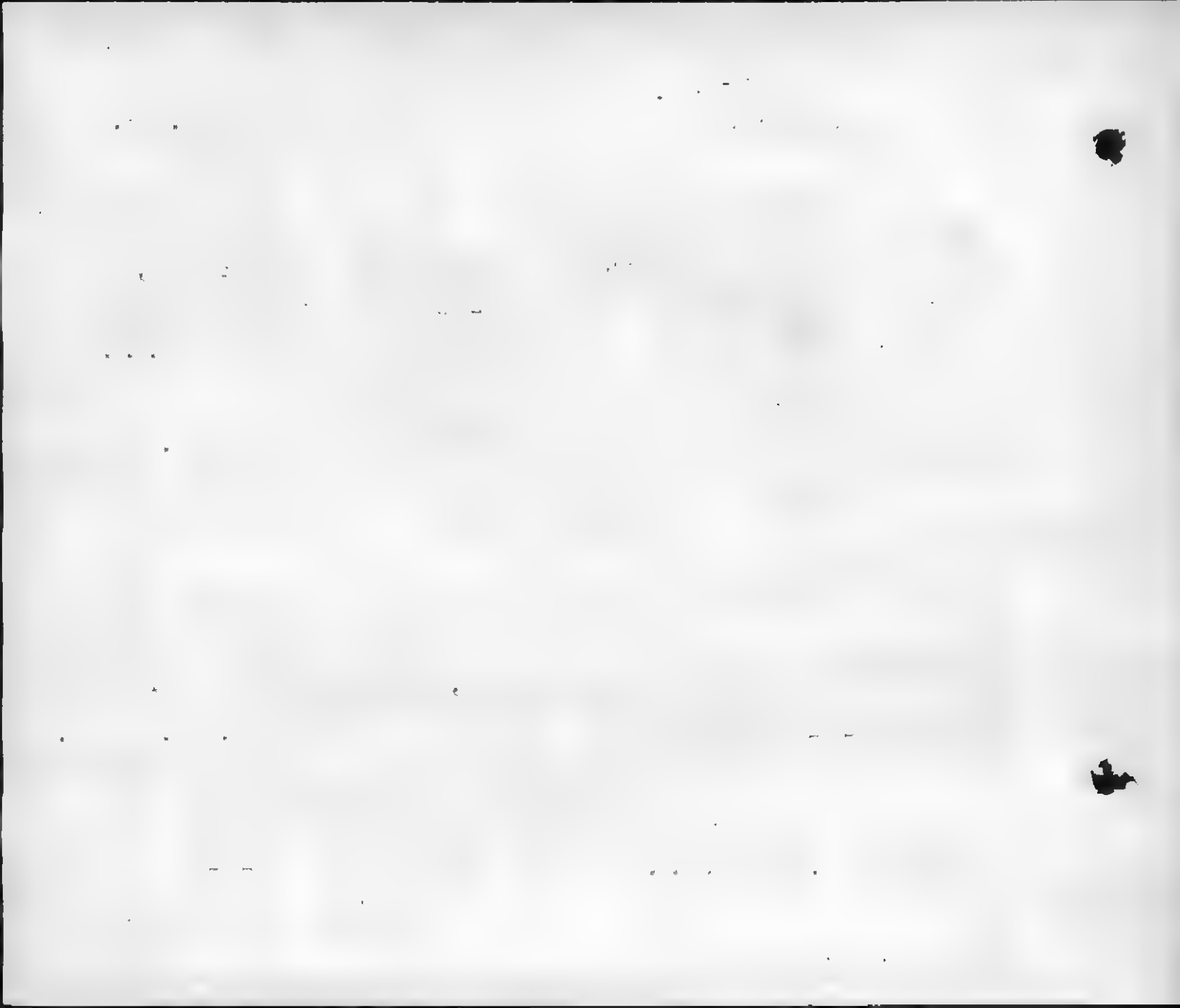
12880

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowie</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5th Street</b>				e. STREET ADDRESS <b>5th Street</b>			
3. NAME OF DECEASED (Type or print) First Middle Last				4. DATE OF DEATH Month Day Year			
<b>Mary Elisabeth Tayler</b>				<b>November 15, 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-21</b>	9. AGE (in years last birthday) <b>37</b> yrs	10. UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Brown</b>				14. MOTHER'S MAIDEN NAME <b>Mary Wood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO		17. INFORMANT <b>Gus Taylor; Same address as # 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage and shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Shotgun wound of head</b> DUE TO (c) <b>Gun shot wound of head, caused by another person.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <b>8:40 P.M. 11-15-1958</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>				20f. (City or town) <b>Bowie</b> (County) <b>Pr. Geo.</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John J. Maloney</b>				DATE SIGNED			
EXAMINER'S NAME (Type) <b>John T. Maloney, M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>11-16-58</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>11-22-58</b>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <b>Church of Ascension</b>				22d. LOCATION (City, town, or county) <b>Bowie Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington</b>				24a. REC'D BY REGISTRAR <b>NOV 20 '58</b>			
ADDRESS <b>467 N. St NW</b>				24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12852

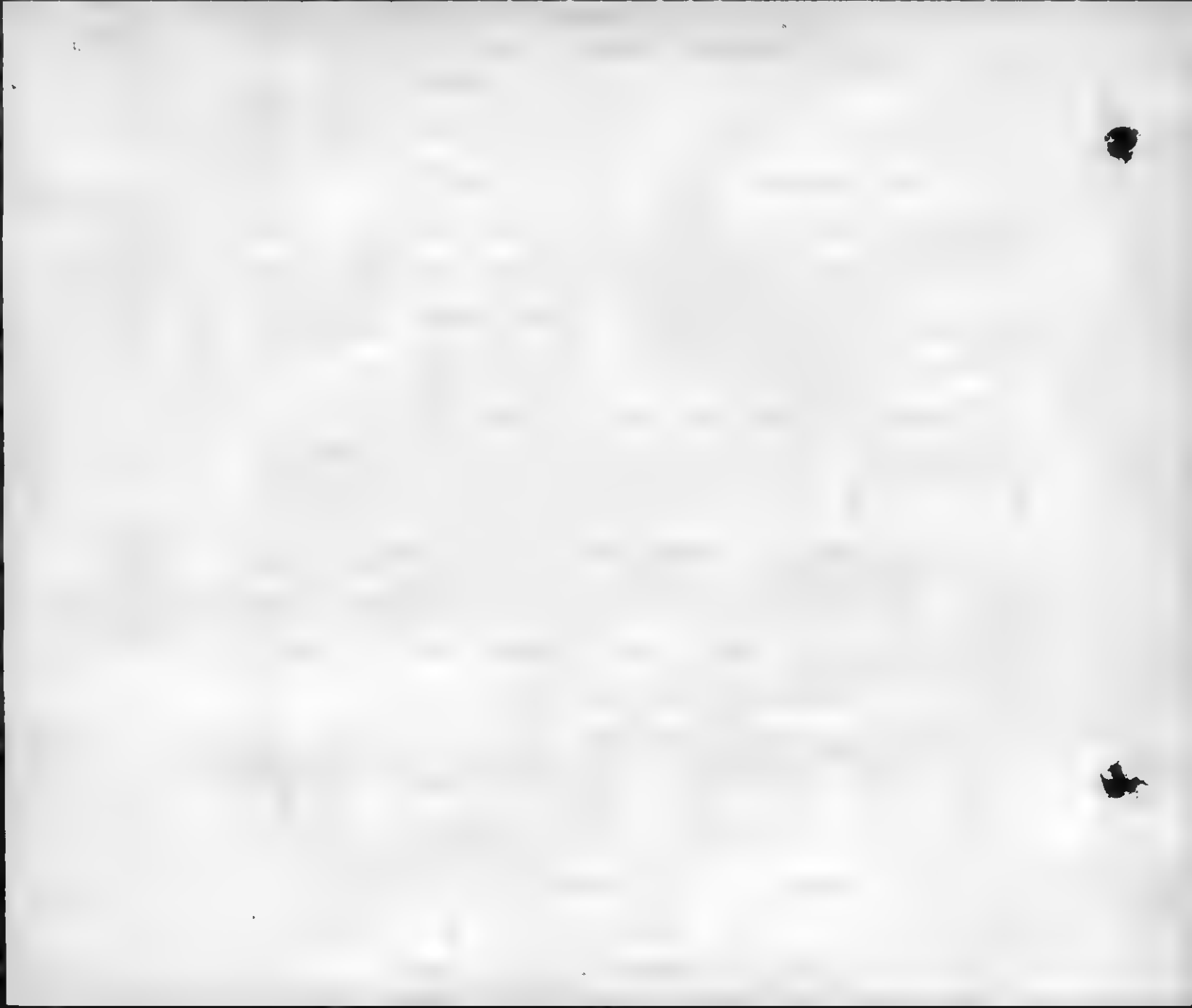
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12881

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>				c. LENGTH OF STAY IN 1b <u>2-0-4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen. Hosp</u>				e. STREET ADDRESS <u>1032 Brady Ave --</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ann</u> <u>Rosalie</u> <u>Thompson</u>				4. DATE OF DEATH Month Day Year <u>11-9-</u> <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-11-01</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John E. Lloyd</u>				14. MOTHER'S MAIDEN NAME <u>Frances Macabe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Albert Thompson</u> Address <u>Same address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x</u> DUE TO <u>Acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular renal disease</u> (c) <u>stating the underlying cause last.</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>John J. Maloney</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JOHN J. MALONEY MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-9-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church of Ascension</u>		22d. LOCATION (City, town, or county) (State) <u>Bowie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton L. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





## CERTIFICATE OF DEATH

Reg. Dist. No.

12882

12853

1. PLACE OF DEATH a. COUNTY <u>Harford</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riversdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4512 Riversdale Rd</u>				d. STREET ADDRESS <u>4512 Riversdale Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>F</u> Last <u>THOMPSON</u>		4. DATE OF DEATH Month <u>NOV.</u> Day <u>11</u> Year <u>1958</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 1881</u>	9. AGE (In years last birthday) <u>77 yrs.</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Hamburg, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Fryer</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Schwartz</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Dr. F. V. Thompson - 1125</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last, (b) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>15 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>11</u> , to <u>11/11</u> , 19 <u>58</u> ; that I last saw the deceased alive on <u>10/18</u> , 19 <u>58</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Baltimore, Md.</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>W. H. Townsend</u> M.D. <u>14 E. Egan St</u>							
PHYSICIAN'S NAME (Type) <u>W. H. TOWNSEND</u> <u>Baltimore, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>11/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sam J. Lieber &amp; Sons - Baltimore</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>Nov 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12804

## CERTIFICATE OF DEATH

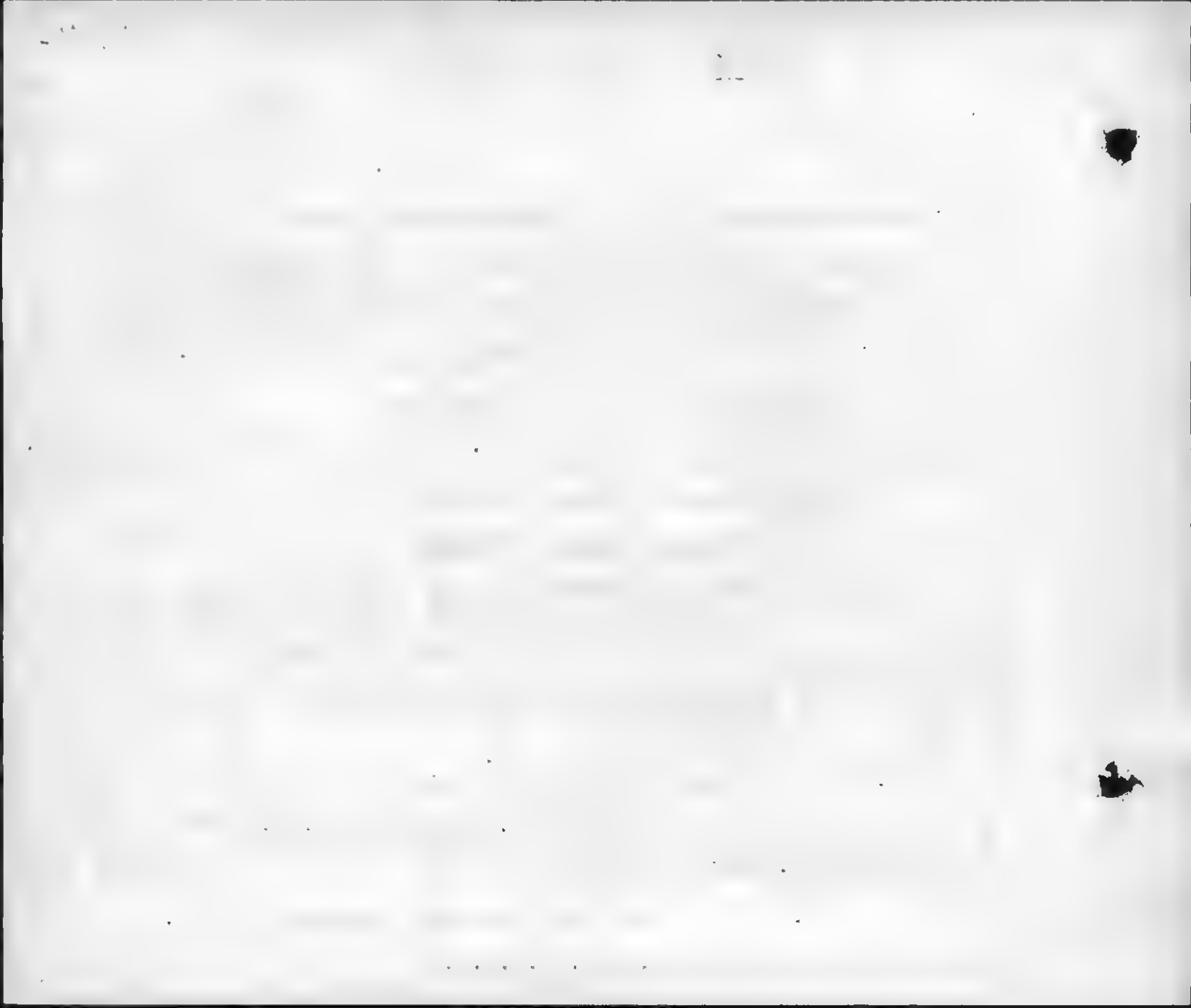
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Hyattsville</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>				c. LENGTH OF STAY IN 1b <b>3 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6611 Stockton Lane</b>				/ d. STREET ADDRESS <b>6611 Stockton Lane</b>			
3. NAME OF DECEASED (Type or print) <b>James T Townsend</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1, 1871</b>		9. AGE (In years last birthday) <b>87 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>James Towensend</b>			14. MOTHER'S MAIDEN NAME <b>Liza Jane</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Lewis H. Boss 6611 Stockton Lane Hyatts.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, Acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Cardio</b> DUE TO (c) <b>Vascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 1955</b> to <b>Nov. 18 1958</b> that I last saw the deceased alive on <b>Nov. 18 1958</b> and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>Robert R. Hottel</b> <b>1222 Monrow St. N.E. Wash. D.C.</b>							
ACTUAL SIGNATURE			PHYSICIAN'S NAME (Type) <b>Robert R. Hottel</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Nov. 21 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Deal Funeral Home</b>			ADDRESS <b>4812 Ga. Ave. N.W.D.C.</b>		24a. REC'D BY REGISTRAR <b>NOV 2 8 58</b>		24b. REGISTRAR'S SIGNATURE <b>Robert R. Hottel</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



12805

## CERTIFICATE OF DEATH

12884

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HYATTSVILLE CONVALESCENT HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Julia B Tracey</u>		4. DATE OF DEATH Month Day Year <u>Nov. 2 1958</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 9 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Smith</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA J. Reeves</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>THOMAS B. NOONE</u>		Address <u>Cheverly 4 Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO VASCULAR ACCIDENT.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>5 YRS.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>NONE.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>11/2</u> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 1, 1953</u> , to <u>11/2, 1958</u> , that I last saw the deceased alive on <u>11/2, 1958</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Seymour Greenbaum</u> M.D.		ADDRESS (Street, city or town, state) <u>400-17 ST. N.W.</u> DATE SIGNED <u>11/4/58</u>	
PHYSICIAN'S NAME (Type) <u>SEYMOUR GREENBAUM, M.D.</u>		<u>WASHINGTON 6, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lakeview</u>	22d. LOCATION (City, town, or county) (State) <u>HAMILTON Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Lee Jones</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>NOV 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12806

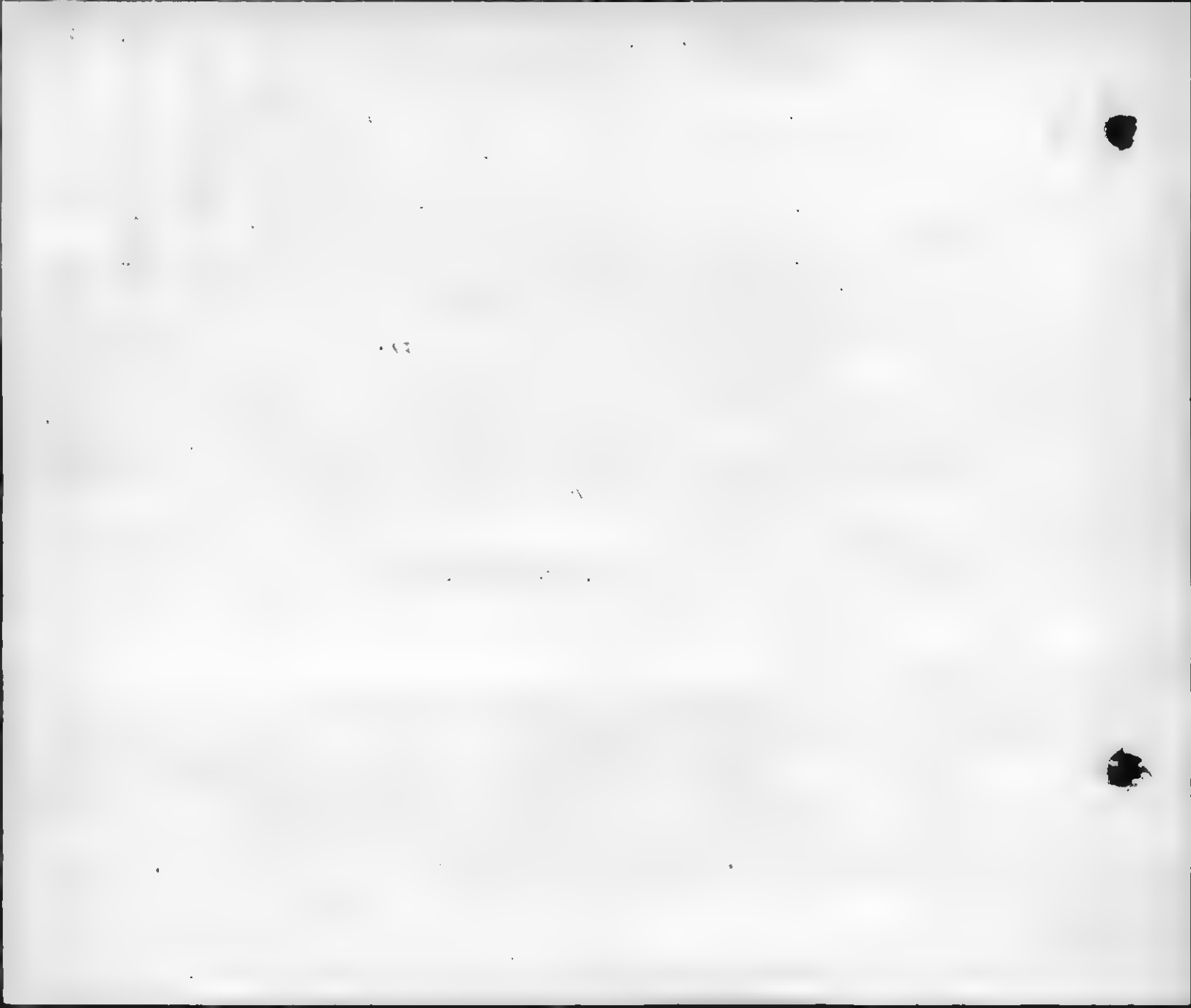
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE, MD.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1-4917- RUSSELL AVE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CARROLL MANOR</u>		e. STREET ADDRESS <u>1 HYATTSVILLE, MD.</u>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>L.</u> Last <u>TYLOR</u>		4. DATE OF DEATH Month <u>11</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-13-76</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WINDOW DRESSER-CLERK - LOEB Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE TYLOR</u>		14. MOTHER'S MAIDEN NAME <u>ISABELLE BUCHANAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-03-83724</u>	
17. INFORMANT <u>Sister M. Joan Theresa O. Gorm.</u>		Address <u>Carroll Manor</u>	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis</u> DUE TO (c) <u>Senile arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Prostate</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 9, 1928</u> , to <u>Nov 5, 1958</u> , that I last saw the deceased alive on <u>Nov 1, 1958</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>4601 16th St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD H. SPIRE</u>		DATE SIGNED <u>11/5/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins 3821-14th St. N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12890

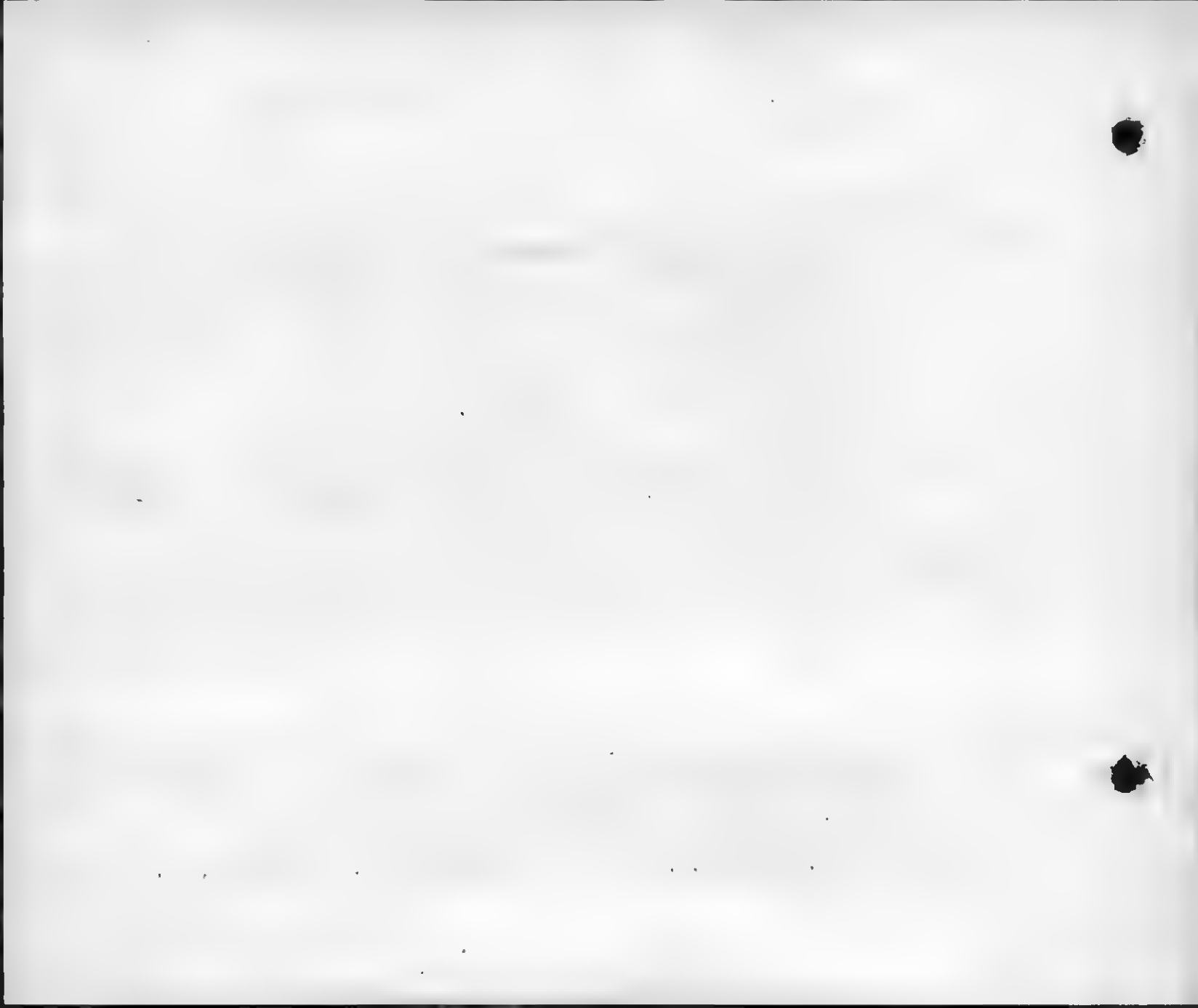
## CERTIFICATE OF DEATH

12886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park, Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Palmer Park, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8212 Sherrill St		d. STREET ADDRESS 8202 Sherrill St			
3. NAME OF DECEASED (Type or print) Charles Harvey Watkins		4. DATE OF DEATH Month November 19, 1958			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/17/31		
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Printing			
11. BIRTHPLACE (State or foreign country) Washington D. C.		12. CITIZEN OF WHAT COUNTRY U S A			
13. FATHER'S NAME Charles W Watkins		14. MOTHER'S MAIDEN NAME Elsie M Sherry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO (If yes, give war or dates of service)			
17. INFORMANT Audrey Watkins Palmer Park, Md.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1930 Malignant Brain tumor DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			INTERVAL BETWEEN ONSET AND DEATH 14 Mo		
21. I certify that I attended the deceased from Sept. 7, 1957 to Nov 19, 1958, that I last saw the deceased alive on Nov 18, 1957, and that death occurred at 2 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED November 19, 1958			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
ACTUAL SIGNATURE William D. Rosson M.D.		DATE SIGNED November 19, 1958			
PHYSICIAN'S NAME (Type) WILLIAM D. ROSSON, M.D.		5304 Annapolis rd., Bladenburgh, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 21, 1958		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
22d. LOCATION (City, town, or county) Arlington Virginia		22e. ADDRESS Hyattsville, Maryland		22f. DATE NOV 24 '58	
23. FUNERAL DIRECTOR'S SIGNATURE L. Gasch's Sons		23a. REC'D BY REGISTRAR NOV 24 '58		23b. REGISTRAR'S SIGNATURE Charles S. Kenna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12887

## 12807 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>PRINCE GEORGE COUNTY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON, D.C.</b>			
c. LENGTH OF STAY IN 1b <b>6 months</b>				d. STREET ADDRESS <b>1608 East West Hgwy.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CARROLL MANOR</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Loretto L Watt</b>				4. DATE OF DEATH <b>NOV. 3 1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 19, 1872</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM BOARMAN</b>				14. MOTHER'S MAIDEN NAME <b>AMANDA DEAKINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>NO</b> (If yes, give war or dates of service)				17. INFORMANT <b>Mrs. Jessie M. Miller 1608 East West Hgwy.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Ampulla of Vater - with metastases</b> DUE TO <b>water</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan. 11-3, 1958</b> , that I last saw the deceased alive on <b>11-2, 1958</b> , and that death occurred at <b>11:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4201 Mass. Ave. NW Wash. 16 DC.</b> DATE SIGNED <b>11-3-58</b>							
ACTUAL SIGNATURE <b>R. M. Tilley, Jr. M.D.</b>				PHYSICIAN'S NAME (Type) <b>Wash. 16 DC.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-6-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins 3821-14th St. NW</b>				24a. REC'D BY REGISTRAR <b>Nov 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 12854 12888 12854 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 14 College Park			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General				d. STREET ADDRESS 5020 Quebec St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Eugene Middle Joseph Last Weber				4. DATE OF DEATH Month November Day 25 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-3-03	9. AGE (In years last birthday) 55 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ordnance supintendent				10b. KIND OF BUSINESS OR INDUSTRY Naval Gun Factory		11. BIRTHPLACE (State or foreign country) Michigan	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Eugene Edward Weber				14. MOTHER'S MAIDEN NAME Mary Crimmin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) yes 1920 to 1925				16. SOCIAL SECURITY NO.			
17. INFORMANT Hazel M. Weber, Wife				Address College Park, Md. 5020 Quebec St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 12:54, 19, to 11:25, 19 58, that I last saw the deceased alive on 11-25-58, 19, and that death occurred at 8:15 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr. Ronald S. Fleisher				ADDRESS (Street, city or town, state) 5432 QUEENS CHAPEL RD. HYATTSVILLE, MD.			
DATE SIGNED 11/26/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 29, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '58	
24b. REGISTRAR'S SIGNATURE							



12855

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>	
c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Capitol Heights</u>	
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Gen Hosp</u>		4. STREET ADDRESS <u>6333 Brooks Road</u>	
5. NAME OF DECEASED (Type or print) <u>Herbert</u> <u>Brindell</u> <u>White</u>		6. DATE OF DEATH <u>NOVEMBER</u> <u>11</u> <u>1958</u>	
7. SEX <u>Male</u>	8. COLOR OR RACE <u>Col.</u>	9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	10. DATE OF BIRTH <u>12-15-27</u>
11. AGE (In years last b. day) <u>34</u> yrs		12. IF UNDER 24 HRS <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		14. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
15. BIRTHPLACE (State or foreign country) <u>Maryland</u>		16. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
17. FATHER'S NAME <u>Roland White</u>		18. MOTHER'S MAIDEN NAME <u>Irene Pinkney</u>	
19. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		20. SOCIAL SECURITY NO <u>577-40-1783</u>	
21. INFORMANT <u>Address</u>		22. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
23. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage &amp; shock</u> DUE TO (b) <u>Ruptured left lung</u> DUE TO (c) <u>Crushed chest.</u>		24. INTERVAL BETWEEN ONSET AND DEATH	
25. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		26. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
27. 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		28. 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Accident of a parked car struck by another automobile</u>	
29. 20c. TIME OF INJURY Month, Day, Year <u>Hour</u> <u>11-7</u> <u>1958</u>		30. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	
31. 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		32. 20f. CITY OR TOWN (County) (State) <u>Sandover Pr Geo Md</u>	
33. 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
34. ACTUAL SIGNATURE <u>John T. Maloney</u>		35. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
36. EXAMINER'S NAME (Type) <u>JOHN T. MALONEY M.D.</u>		37. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
38. 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>11-12-58</u>		39. 22b. DATE THEREOF <u>11-12-58</u>	
40. 22c. NAME OF CEMETERY OR CREMATORY <u>Ridgely Cemetery</u>		41. 22d. LOCATION (City, town or county) (State) <u>Central Ave Sandover Md</u>	
42. 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry S. Washington</u>		43. 24. REC'D BY REGISTRAR <u>NOV 13 '58</u>	
44. ADDRESS <u>467 Nat ne</u>		45. 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

12891

## CERTIFICATE OF DEATH

12890

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>DISTRICT OF COLUMBIA</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANDREWS AIR FORCE BASE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4432 E. ST. SE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>4432 E. ST. SE</u>		d. STREET ADDRESS <u>WASHINGTON D.C.</u>	
3. NAME OF DECEASED (Type or print) First <u>LEONDRAS</u> Middle <u>WHITELOW</u> Last <u>WHITELOW</u>		4. DATE OF DEATH Month <u>NOV</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>NEGROID</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>17 SEPT 58</u>
9. AGE (In years last birthday) yrs. <u>2</u> Months <u>12</u> Days <u>12</u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>USAF HOSP-ANDREWS.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>ANDREWS AFB, WASH 25, D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>ALONZO WHITELOW</u>	
14. MOTHER'S MAIDEN NAME <u>GLORIA HELEN CABITT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO <u></u>		17. INFORMANT Address <u>ALONZO WHITELOW-FATHER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO <u>Gastroenteritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 or 3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>29 Nov., 1958</u> , to <u>D.O.A.</u> , 19 <u></u> , that I last saw the deceased alive on <u>29 Nov. 1958</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Arthur J. Deikman</u>		ADDRESS (Street, city or town, state) <u>USAF Hospital Andrews</u> DATE SIGNED <u>29 Nov 58</u>	
PHYSICIAN'S NAME (Type) <u>ARTHUR J. DEIKMAN</u>		Address <u>Andrews AF Base, Washington 25, D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u></u>	22b. DATE THEREOF <u>12/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins</u> ADDRESS <u>4804 E. Ave</u>		24a. REC'D BY REGISTRAR <u>DEC 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>



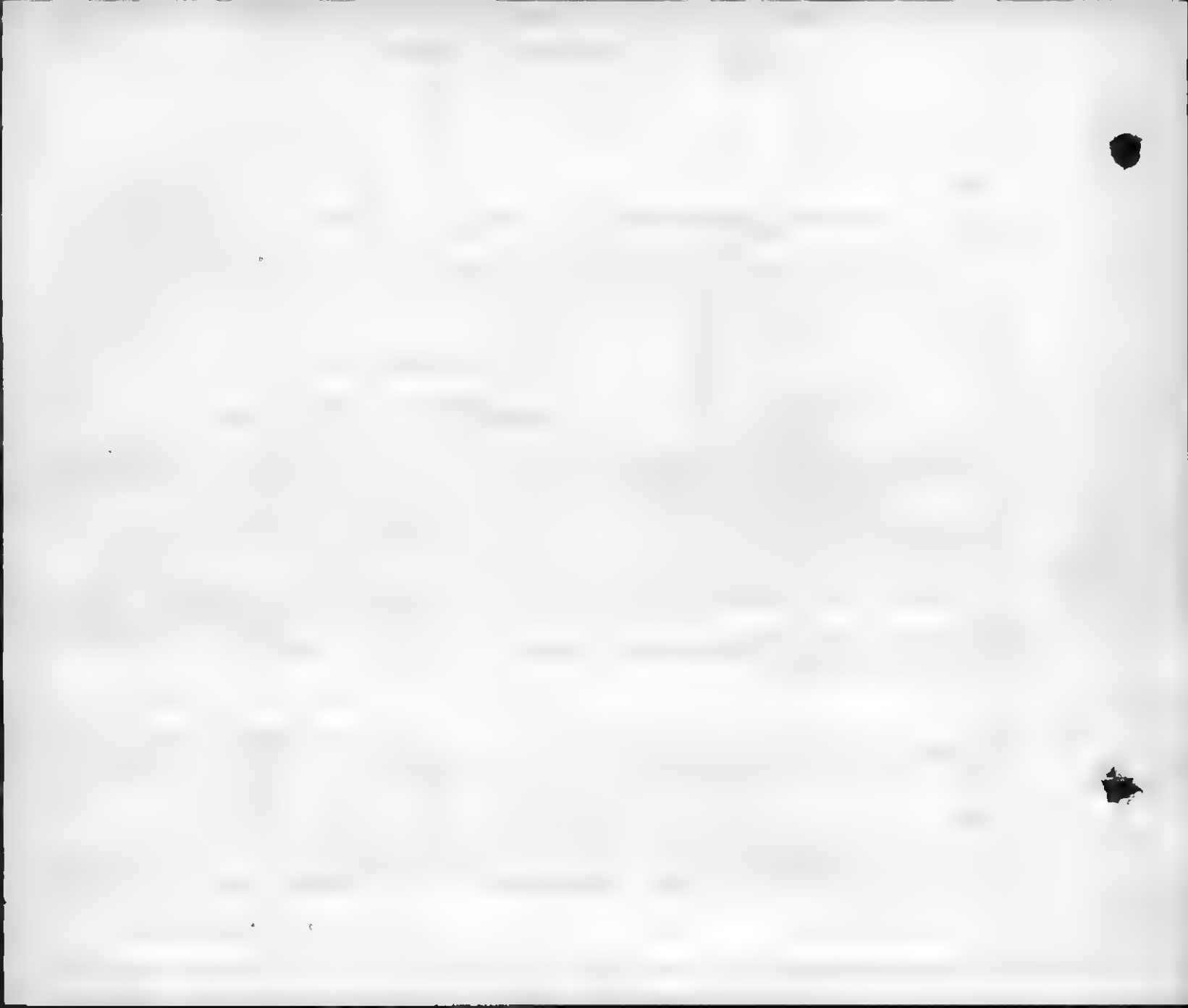
12892

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Hill		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Silver Hill	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d STREET ADDRESS	
3 NAME OF DECEASED (Type or print) Clara Adelaide Willett		4. DATE OF DEATH Nov. 2 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY self	9. AGE (In years last birthday) 85 yrs
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME William A. Murry		14. MOTHER'S MAIDEN NAME Sarah Hamilton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs Ruth Willett
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 1 week 1 year 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1956 to Nov 2, 1958, that I last saw the deceased alive on Nov 1, 1958, and that death occurred at 5:40 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE John P. DeAngelo M.D.		DATE SIGNED Nov 2, 1958	
PHYSICIAN'S NAME (Type) John P. DeAngelo M.D.		ADDRESS (Street, city or town, state) Silver Hill, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 5 1958	22c. NAME OF CEMETERY OR CREMATORY St. Paula Cemetery	22d. LOCATION (City, town, or county) (State) Waldorf, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home		24a. REC'D BY REGISTRAR DATE NOV 5 '58	
ADDRESS Waldorf, Md.		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached and used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

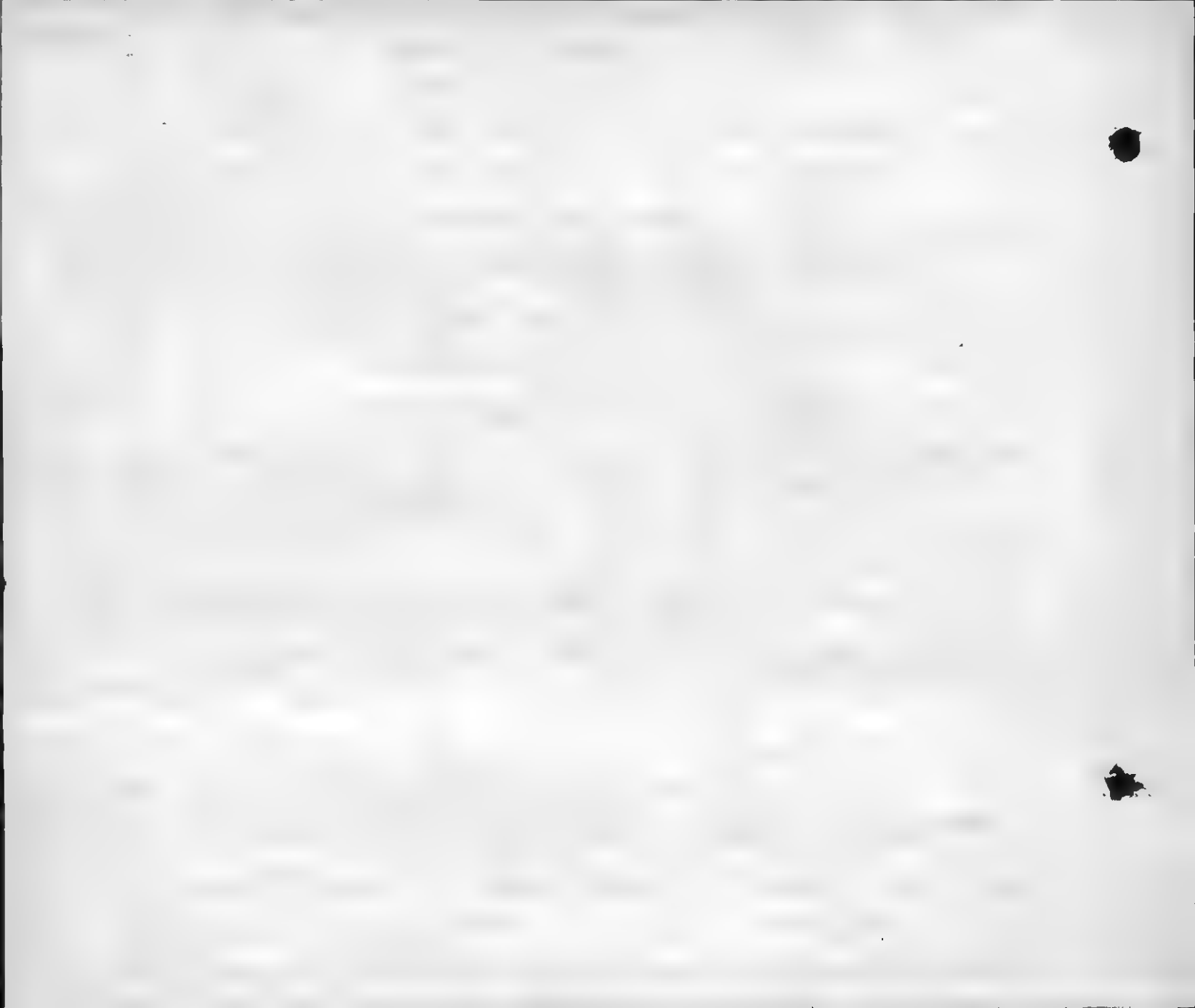
12893

## CERTIFICATE OF DEATH

Reg. Dist. No.

12892

1. PLACE OF DEATH a. COUNTY <b>PR. GEORGE CO.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <b>MARYLAND</b> c. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPALDING HEIGHTS</b>				c. LENGTH OF STAY IN 1b <b>8 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1604 - 60th Street, S.E.</b>				d. STREET ADDRESS <b>1604 - 60th Ave., S.E.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE THOMAS WILLIAMS</b>				4. DATE OF DEATH Month Day Year <b>NOVEMBER 23, 1958</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1879</b>	9. AGE (In years last birthday) <b>79 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GLASS BLOWER - RET. - WINDOW GLASS</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PITTSBURG, PA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN WILLIAMS</b>				14. MOTHER'S MAIDEN NAME <b>EMILY WILLIAMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>578-24-0573</b>			
				17. INFORMANT Address <b>MARY BLANCHE WILLIAMS - WIFE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X</b> DUE TO <b>Carcinoma of Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastases</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>7 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 1958</b> to <b>June 28, 1958</b> that I last saw the deceased alive on <b>June 28, 1958</b> and that death occurred at <b>5:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T. T. O'Donovan</b> M.D.				ADDRESS (Street, city or town, state) <b>284 Labadie St. N.W.</b>			
DATE SIGNED <b>11/23/58</b>							
PHYSICIAN'S NAME (Type) <b>T. T. O'Donovan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-26-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		22d. LOCATION (City, town, or county) (State) <b>WHEATON, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. M. Ryan, Inc. 3174 Ave. S.E.</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. ...</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12856

## CERTIFICATE OF DEATH

12893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheverly</b>		c. LENGTH OF STAY IN 1b <b>6217 Foote St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Seat Pleasant,</b>		d. STREET ADDRESS <b>6217 Foote St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph R Wood</b>		4. DATE OF DEATH Month Day Year <b>11-7 1958</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-19-58</b>		9. AGE (In years last birthday) yrs <b>2</b> Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph F Lloyd.</b>		14. MOTHER'S M maiden NAME <b>Mary ann. Wood.</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mother. 6217 Foote St. Seat Pleasant Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lung abscess, L.L.L.</b> 493X DUE TO <b>Pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>? aspiration</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 wk</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>none</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>11-3 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>640 P</b>		20f. (City or town) <b>Seat Pleasant</b>		(County) <b>Prince Georges</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>11-3</b> , 19 <b>58</b> , to <b>11-7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-3</b> , 19 <b>58</b> , and that death occurred at <b>640 P</b> M, from the causes and on the date stated above.		22. I certify that I attended the deceased from <b>11-3</b> , 19 <b>58</b> , to <b>11-7</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-3</b> , 19 <b>58</b> , and that death occurred at <b>640 P</b> M, from the causes and on the date stated above.		23. ACTUAL SIGNATURE <b>Max M Herzberg</b>		24. ADDRESS (Street, city or town, state) <b>7016 Grey St, Seat Pleasant, Md.</b>		25. DATE SIGNED <b>Nov 12 1958</b>		26. PHYSICIAN'S NAME (Type) <b>Max M Herzberg M.D.</b>		27. SIGNATURE <b>W. W. Chambers</b>	
28. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		29. DATE THEREOF <b>11-10-58</b>		30. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		31. LOCATION (City, town, or county) <b>Suitland, Maryland</b>		32. (State) <b>Md.</b>		33. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers</b>		34. ADDRESS <b>60 Washington, D.C.</b>	
35. REC'D BY REGISTRAR <b>NOV 12 1958</b>		36. REGISTRAR'S SIGNATURE <b>Arthur S. Fines</b>		37. REGISTRAR'S SIGNATURE <b>Arthur S. Fines</b>		38. ADDRESS <b>Arthur S. Fines</b>		39. (City, town, or county) <b>Seat Pleasant, Md.</b>		40. (State) <b>Md.</b>		41. (Country) <b>U.S.A.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12857

CERTIFICATE OF DEATH

Reg. Dist. No.

12894

1. PLACE OF DEATH a. COUNTY <u>Prince George Gen. Hosp. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>25 Riverdale, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George Gen. Hosp.</u>				d. STREET ADDRESS <u>14306 Queensbury Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HAZELE MILLIRON'S YOUNG</u>				4. DATE OF DEATH Month Day Year <u>November 10 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 22, 1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Macon, Georgia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>W. T. Millirons</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles D. Wimpee Sr.</u>		Address <u>4306 Queensbury Rd Riverdale Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 5, 1958</u> to <u>Nov. 10, 1958</u> , that I last saw the deceased alive on <u>November 10, 1958</u> , and that death occurred at <u>6:25 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>George S. Malouf M.D. 5802 Balto. Ave Hyatts. Md. 11/11/58</u>							
ACTUAL SIGNATURE <u>George S. Malouf</u> M.D.							
PHYSICIAN'S NAME (Type) <u>GEORGE S. MALOUF M.D. 5802 Balto. Ave Hyatts. Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Nov. 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO. Riverdale Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12858

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince Georges Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Leonard M. Young</u>				4. DATE OF DEATH <u>Nov. 15</u> 19 <u>58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/8/1906</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1st Col. Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Falls City, Neb.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Edward Young</u>				14. MOTHER'S MAIDEN NAME <u>Ruby Della Vaughn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>Active</u>				16. SOCIAL SECURITY NO. <u>10-11-11-11</u>			
17. INFORMANT <u>Bertha W. Young</u>				Address <u>address above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>acute congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular renal disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/19/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>				22d. LOCATION (City, town, or county) <u>Virginia</u> (State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Halley's Funeral Home, Inc.</u>				24a. REC'D BY REGISTRAR <u>NOV 23 58</u>			
24b. REGISTRAR'S SIGNATURE <u>James D. Hall</u>							

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

11-15-58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City and County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Name of Deceased		Age		Sex		Race		Date of Death	
John Doe		45		Male		White		10/15/1918	
Residence		Occupation		Cause of Death		Manner of Death		Place of Death	
123 Main St, Boston		Carpenter		Heart Disease		Natural		Home	
Physician		Coroner		Medical Examiner		Nurse		Burial Place	
Dr. Smith		Mr. Jones		Dr. Brown		Miss White		Cemetery	
Signature of Medical Examiner		Signature of Coroner		Signature of Physician		Signature of Nurse		Signature of Burial Place	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	